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THE
INSTITUTES AND PRACTICE
OF
SURGERY:

BEING THE
OUTLINES
OF
A COURSE OF LECTURES.

BY
WILLIAM GIBSON, M. D.

PROFESSOR OF SURGERY IN THE UNIVERSITY OF PENNSYLVANIA, SURGEON AND
CLINICAL LECTURER TO THE ALMS-HOUSE INFIRMARY, &c.

*Segnius irritant animos demissa per aurem,
Quam quæ sunt oculis subjecta fidelibus.—Hor.*

FOURTH EDITION, GREATLY ENLARGED.

VOL. II.

PHILADELPHIA:
CAREY, LEA & BLANCHARD:

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“The Institutes and Practice of Surgery: being the Outlines of a Course of Lectures, by William Gibson, M. D., Professor of Surgery in the University of Pennsylvania, Surgeon and Clinical Lecturer to the Alms-House Infirmary, &c.

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Clerk of the Eastern District of Pennsylvania.

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THE
INSTITUTES AND PRACTICE
OF
SURGERY.

CHAPTER I.

DISEASES OF THE NOSE AND ANTRUM.

THE subjects embraced in the first volume of this work correspond, with the arrangement of the anatomical lectures in the University, so closely, that by the time the latter are disposed of, the former may be entered upon. The same correspondence, however, has not existed, hitherto, in the arrangement of the matter of the second volume. To effect this, the distribution of the text, in the present edition, has been altered. If upon any occasion, then, the diseases should appear in this volume disjointed, let it be remembered that accurate collocation has been sacrificed to convenience and expediency. With these views, I commence with diseases of the nose and antrum.

The mucous membrane which lines the cavity of each nostril, not only covers the spongy bones, but extends to the antrum maxillare, to the frontal, ethmoidal and sphenoidal sinuses, and even to the mouth and throat. Hence a similarity of disease is found to pervade each of these parts, the foundation of which may be said to be laid, generally, by inflammation produced by cold, specific diseases, and other causes. The most common diseases of these cavities, are polypous tumours, collections of purulent matter, and ulcerations.

SECTION I.

Polypus of the Nose.

A POLYPUS may spring from any portion of the Schneiderian membrane: it originates, however, most frequently either from the superior or inferior spongy bone. In shape it is usually pyriform—being narrow at its root and expanded below; though this will depend very much upon the natural form of the cavity it occupies. Sometimes the base of the tumour is exceedingly broad. Not unfrequently a polypus originates high in the nose, and instead of falling forwards or towards the anterior nares, takes a backward direction, hangs behind the palate, and sometimes reaches the pharynx. One or both nostrils may be the seat of this disease. When both are filled, the patient breathes with difficulty, and with a peculiar rattling noise. In damp weather, the tumours often project beyond the nose, and contract and disappear as soon as the weather becomes dry. The consistence of polypus is not less variable than its form. Firm, fleshy, and very solid, in some instances: it is upon other occasions extremely soft, and so tender as to tear upon the slightest touch. The most common variety, so far as my experience goes, is that which bears, in consistence, shape, colour and size, a striking similitude to the common oyster. Most polypi are extremely vascular, and if rudely handled, bleed profusely. No age or sex are exempt from the disease, which sometimes assumes a malignant form, at other times destroys the patient, by exciting, from pressure, caries of the spongy ethmoid bones, inflammation of the brain, &c.

Treatment of Polypus of the Nose.

Several operations, very opposite in character, have been practised for the removal of nasal polypus. I prefer in most cases the use of the forceps. These, when properly made, should be stouter than the common dressing forceps, with their extremities slightly curved, serrated, and a considerable slit or hole in each blade, about half an inch from its point. The patient being seated before a strong light on a low chair, with his head moderately thrown back and firmly supported by an assistant, the surgeon carefully introduces the instrument with its blades expanded, as far as the root of the tumour, takes firm hold of it, and by two or three turns of the instrument, instead of pulling in a straight line, twists it away. A copious gush of blood generally follows, especially if the tumour be partially removed. Clearing this away, the forceps are again and again introduced until the whole nostril be free, the strongest proof of which will be the freedom with which the patient can breathe or force air through the nostril. In performing this operation, great care must be taken not to use unnecessary violence, because it has sometimes happened that the ethmoid bone has been broken up, and other mischief produced sufficient to lead to fatal consequences. This operation is chiefly adapted to polypi with narrow necks, and confined to the cavity of the nostril.

The operation of *excision* has been recommended by J. Bell, Whately and others, for the removal of polypi of large size and broad base. There are very few cases, it appears to me, requiring such a measure. Independently of the difficulty of the operation, the hemorrhage is always very profuse, and, besides the uncertainty of removing the whole of the disease, the surgeon will run considerable risk of injuring the sound parts in the neighbourhood of the tumour. Mr. Whately employs a sheathed knife, somewhat similar to Dr. Physick's bistoury for fistula in ano.

The *ligature*, although recommended by some writers for every variety of polypus, can seldom be employed advantageously, except where the tumour arises by a narrow neck and hangs beyond the posterior nares. In such cases, a silver or iron wire,

or a piece of catgut, eighteen inches long, should be doubled so as to form a loop, and introduced into the nostril until it appears below the palate, when it should be caught by a pair of narrow forceps, and drawn towards the mouth, and the loop at the same time expanded by the fingers of the surgeon. As soon as this is accomplished, the operator, still holding the loop with one or two fingers, draws the projecting ends of the wire with the other hand from the nostril, and thus by one simultaneous movement, carries the loop over the base of the polypus, and thence to its neck. The ends of the wire are next passed through the double cannula of Levret, and after being drawn so firmly as to constrict the neck of the polypus, are twisted upon the wings of the instrument and secured. In proportion as the wire becomes loose from the shrinking of the tumour, its ends must be tightened every few hours until the polypus drops off, which it does sometimes so suddenly as nearly to suffocate the patient. If the surgeon should experience any difficulty, as he often does, in introducing the wire and noosing the polypus in the manner directed, he may resort with advantage to the cannula of Bellocque.

Whatever method may be practised for the removal of polypus, there are two points which must always be particularly attended to—the suppression of hemorrhage, and the removal of any fragments of the tumour so situated as to elude the instruments directed against them. The first may be accomplished, generally, by cold astringent solutions thrown up the nostrils by a syringe, or if these do not succeed, by passing a catgut, to which two or three dossils of lint are secured, through the nostril and mouth. The pressure thus created, hardly ever fails to stop the flow of blood. To guard against the return of the disease, from portions of the tumour being left behind, the *argentum nitratum*, repeatedly applied, will be found the most effectual remedy.

See *Pott's Chirurgical Works*, by Earle, vol. 3, p. 165—*J. Bell's Principles of Surgery*, vol. 3, p. 89—*Whately's Cases of two extraordinary Polypi removed from the Nose, the one by Excision with a new Instrument, the other by Improved Forceps*, 8vo. 1805—*Callisen's Systema Chirurgiæ Hodiernæ*, vol. 2, p. 207—*Lassus' Pathologie Chirurgicale*, tom. 1, p. 528—*Deschamps' Traité des Maladies des Fosses Nasales, &c.*—*C. Bell's Operative Surgery*, vol. 1, p. 208.

SECTION II.

Ozæna.

A TROUBLESOME ulceration of the lining membrane of the nostrils, attended with fetid discharge, and sometimes followed by destruction of the cartilage and by caries of the bones of the nose, is denominated by most modern writers ozæna. The origin of the disease is very obscure, though there is reason to believe that, in most instances, it is connected with the primary or secondary forms of syphilis. In other instances, marks of the purely scrofulous character are apparent. One of the most troublesome attendants of the disease is the accumulation of inspissated mucus, or of incrustations in the cavities of the nose. These are sometimes so considerable in quantity, as to block up entirely the passages. After the ulceration is fairly established, it not only takes possession of the cartilaginous septum, the ethmoid and spongy bones, and the other bones of the nose, but extends to the cheek. If the patient should recover after such ravages, he must for ever remain horribly deformed.

Treatment of Ozæna.

The remedies best adapted to the cure of ozæna are bark, iron, the mineral acids, muriate of lime, sarsaparilla, and antimony. When there is any suspicion of the disease having originated from syphilis, mercury alone, or conjoined with other preparations, should be employed. During the height of the inflammation, solutions of opium and of the acetate of lead, may be injected into the nostrils, or applied to the ulcerated surface on lint.

Some of the mild animal oils introduced into the cavities of the nose, will also prove serviceable, by softening the incrustations and lessening pain. After the inflammation has abated, more stimulating materials may be employed, such as solutions of lunar caustic, sulphate of copper, the ointment of the red oxide of mercury, citrine ointment, &c.

Within the last five years, *chloride of lime* has been recommended, particularly in ozæna, by Dr. Horner. The first case in which it was tried was a very inveterate one of several years' standing, large quantities of very fetid matter being constantly discharged from both nostrils, and after passing into the stomach occasioning great sickness and loss of appetite. A tea-spoonful of chloride of lime was put into a wine-glass full of water; the clear solution was then injected into each nostril twice a-day, and the practice having been continued for a few weeks, a perfect cure was accomplished. Other similar instances have been reported, but time will show whether the medicine can be depended upon in the generality of cases.

On the subject of Ozæna, consult Pearson's Principles of Surgery, p. 279—Horner's Case of Ozæna, in American Journal, No. XI, May, 1830.—Craighie's Case of Pereostitis with Ozæna, in Ed. Medical and Surgical Journal, for January, 1834.

SECTION III.

Polypus of the Antrum.

FUNGUS or polypus of the antrum maxillare, is less frequently met with than abscess of that cavity—a disease already treated of in another place.* It is, however, one of the most formidable affections in surgery, and unless speedily arrested, generally proves fatal. The tumour sprouts from the lining membrane of the antrum, from what cause it is always exceedingly difficult to determine, and grows with more or less rapidity, until it fills the whole of the cavity. By this time, considerable pain is experienced in the cheek and eye of the affected side, and soon after a perceptible enlargement of the face may be observed. These symptoms are, in the course of time, followed by distortion of the nose, projection of the eye, enlargement of the gums corresponding to the antrum, profuse discharges of sanious fetid matter, and finally by protrusion of the bones of the face and alveolar processes, and, as a necessary result, by hideous deformity. In consistence, the tumour is generally firm and fleshy, sometimes soft, and in a few rare instances, osteo-sarcomatous or even bony.

*Treatment of Polypus of the Antrum.*

If, instead of temporizing, as is too common, until the disease is so advanced as to leave no reasonable hope of effecting a

* See Vol. I. p. 128.

cure, the surgeon were always to follow the practice of the enlightened and fearless Desault, and operate at an early period, most patients, perhaps, would recover. As soon, therefore, as the nature of the tumour is ascertained, the surgeon should not only determine to remove it, but resolve to set no limits to the sacrifices it may be necessary to make. With this view he must provide himself with several curved and angular scalpels, of unusual strength and thickness, two or three cauterizing irons, a key for pulling teeth, chisels, gouges, a mallet, &c. Every arrangement being made, the surgeon first separates, with a common scalpel, the cheek from the maxillary bone, by opening the patient's mouth as widely as possible, and cutting through the internal membrane. His next object should be to remove the molares teeth and their alveolar processes corresponding with the floor of the antrum. This may be done by the tooth key, or by two or three strokes of a gouge and mallet. Having in this way exposed the cavity of the antrum and the surface of the tumour, the curved and angular knives must then be employed until every remnant of the disease is rooted out. The hemorrhage that follows the operation is sometimes extremely profuse, but may be instantly arrested, and with little pain to the patient, by one or two applications of the cautery. I have, however, performed several operations of the kind without ever being under the necessity of doing more towards stopping the flow of blood than plugging the antrum with lint or tow. If the operation prove successful, the antrum is filled in a few weeks with healthy granulations; but if the disease return, this is soon rendered evident by the reappearance and rapid growth of the fungus. To repress this, repeated applications of caustic, or the cautery, will be found necessary, or perhaps a second operation may be demanded. Sometimes the teeth and alveolar processes appear sound. In such cases, an incision should be made through the cheek from its outer surface, the anterior walls of the antrum perforated by a trephine, and the tumour removed through the opening.

I say nothing of the modern proposal of curing polypus of the antrum by tying the carotid, because I have reason to believe that all attempts of the kind hitherto made, (in which the ligature of this vessel was entirely depended upon,) have proved abortive. I should conceive it equally unnecessary, and

not less reprehensible, first to tie the carotid, and afterwards to extirpate the tumour, inasmuch as the patient's danger must be increased tenfold, and without any adequate compensation.

Cases occur, now and then, in which *spontaneous* cures of this formidable disease are effected. Twelve or fourteen years ago, a mulatto man with a large fungus of the antrum, came to me from Petersburg, Virginia, but refused to submit to an operation, and returned home. From that period the tumour ceased to grow, and never afterwards, I have reason to believe, occasioned inconvenience. Seven years ago, a negro man from Fredericktown, Maryland, visited Philadelphia and consulted me respecting a similar tumour of the antrum. I advised the operation, but he, also, refused to submit to it. A few months afterwards, the inflammation subsided, and eventually, the tumour was *converted into bone*. It has so remained ever since, is now entirely free from pain, and the health of the patient has long been excellent.

Consult *Desault's Works*, by Smith, vol. 1, p. 141—*Desault's Parisian Surgical Journal*, vol. 1, and 2—*Traité des Maladies Chirurgicales, et des Operations qui leur Conviennent* par MM. Chopart, et Desault, tom. 1, p. 195—*J. L. Deschamps' Traité des Maladies des Fosses Nasales et de leur Sinus—Suite d'Observations sur les Maladies des Sinus Maxillaire*, par M. Bordenave, in *Memoirs de l'Academie Royale de Chirurgie*, tom. 13, edit. duodecimo, p. 367—*Abernethy's Account of a Singular Disease in the Upper Maxillary Sinus*, in *Transactions of a Society for the Improvement of Medical and Chirurgical Knowledge*, vol. 2, p. 309—*Gibson on Bony Tumours*, in the *Philadelphia Journal of the Medical and Physical Sciences*, vol. 3, p. 100—*C. Bell's Surgical Observations*, vol. 1, p. 413.

CHAPTER II.

DISEASES OF THE MOUTH.

UNDER this head may be included several diseases, some of which have already been treated of in the preceding volume. The principal affections of the mouth, and of the parts in its immediate vicinity, are hare lip, cancer of the lip,* cancer of the tongue,† ranula, malformation of the frænum linguæ, enlargement of the tonsils, elongation of the uvula, epulis or scirrhus of the gums, and caries of the teeth. To give even a general account of the diseases of the teeth, and of the various operations practised upon them, would alone occupy a volume. The present state of surgical science, however, and the subdivision of professional labour, would seem to obviate altogether the necessity of treating of these affections in a work of this description.

SECTION I.

Labium Leporinum, or Hare Lip.

THIS is a congenital deformity, and takes its name from a supposed resemblance to the lip of a hare or rabbit. There are two varieties of the disease—the single and double. The former is the most common, and is a simple fissure or slit, extending

* See Vol. I. p. 171.

† Vol. I. p. 174.

from the edge throughout the substance of the lip to a greater or less extent: the latter is comparatively rare, and differs from the single variety chiefly in having a wider opening, and an intermediate hanging portion. Both varieties are often complicated with a cleft or opening in the bones of the palate. The upper lip is in nine cases out of ten the seat of the disease, and the borders of the fissure are invariably rounded, and covered with the red and delicate membrane peculiar to the edges of the natural lips. Hare lip, independently of its deformity to the infant, proves a serious inconvenience by interfering with its powers of suction, and to the adult by interrupting speech, and preventing the articulation of labial sounds. Sometimes one or more of the incisor teeth project from the upper part of the hare lip nearly in a horizontal direction, and add very much to the deformity.

Treatment of Hare Lip.

The only effectual remedy for hare lip is an operation, and the sooner this is performed the better. If the fissure in the lip is single, it will be sufficient to remove each of its rounded edges in the following way. The infant being firmly held in the arms of a nurse, or laid on a pillow with its head elevated and securely fixed by an assistant, the surgeon having previously separated the internal membrane of the mouth and its frænum, introduces between the lip and gums a narrow flat piece of wood five or six inches long. This being held by another assistant, the operator himself stretches the lip upon the board, and commencing near the nostril, makes an incision downwards, and at a single cut removes in a straight line the edge of the lip. The opposite edge is next detached in a similar manner, when the chasm left will resemble the letter V inverted. It only remains to draw the edges of the wound together, and retain them by the twisted suture, taking care to commence by passing

a pin first through the hanging edge or lower portion of the lip, instead of the upper. Two or three pins will generally be sufficient. They should be passed horizontally, at regular intervals, and rather nearer the internal than the external surface of the lip. The close contact of the edges of the wound, and the pressure necessarily occasioned by the tightening of the ligatures, are sufficient to arrest the hemorrhage. Each pin should be surrounded by a separate ligature passed about it in the form of the figure 8. In four or five days, the adhesion is usually complete, and the pins may be withdrawn, to prevent them from exciting ulceration.

When the operation for double hare lip is performed, it should be conducted upon the principles just laid down. But four instead of two incisions should be made—one on each side of the intermediate projection, which may then be dove-tailed, as it were, with the outer edges of the lip by one or two pins passed entirely across. The cleft in the bony palate, should it exist, generally closes up, *sua sponte*, provided the operation be not too long delayed. When it is said, “the sooner the operation is performed the better,” it should not be understood that it must be done immediately after birth. Infants of two or three weeks old, are very apt to die in convulsions, from operations. Four or five months after birth, will be a favourable period for the operation.

See *Sabatier de la Médecine Opératoire*, tom. 3, p. 273, 8vo. 1810—*Lassus' Pathologie Chirurgicale*, tom. 3, p. 451—*Richerand's Nosographie Chirurgicale*, tom. 2, p. 255—*Dictionnaire des Sciences Médicales*, tom. 3, p. 55, article *Bec de Lièvre*—*Desault's Works*, by Smith, vol. 1, p. 148—*B. Bell's Surgery*, vol. 4, p. 447—*C. Bell's Operative Surgery*, vol. 2, p. 38—*Kirby's Cases in Surgery*, p. 61.

SECTION II.

Ranula.

AN obstruction of one or more of the ducts of the sublingual gland gives rise to the formation of a semipellucid soft tumour, denominated by the older surgeons ranula—from an imaginary resemblance to the belly of a frog. This tumour is generally filled with saliva, or with a viscid fluid resembling the white of an egg. Sometimes it attains so large a size as to interfere with speech and deglutition, and even to displace the teeth. It arises either from adhesion, or natural imperfection of the duct, or from the lodgement of a calculous concretion within its passage. Children and infants are more subject to the complaint than adults.

Treatment of Ranula.

A simple evacuation of the fluid with a lancet answers no purpose, inasmuch as the opening closes again in a few hours. To effect a permanent cure the cyst must be laid open freely, or a portion of it removed with scissors. The application of caustic may afterwards become necessary.

See *Lassus' Pathologic Chirurgicale*, tom. 1, p. 402—*C. Bell's Operative Surgery*, vol. 2, p. 24—*Callisen's Systema Chirurgiæ Hodiernæ*, vol. 2, p. 108.

SECTION III.

Malformation of the Frænum Linguae.

It sometimes happens, though not so frequently as imagined, that children are born with the frænum of the tongue so short, as to prevent them from sucking. To ascertain whether this be really the case, the surgeon should endeavour to raise the point of the tongue with a spatula. If he should fail in this attempt, and the tongue appears upon examining it on the side to be unnaturally confined, little doubt can remain of the frænum being defective.

*Treatment of Malformation of the Frænum Linguae.*

Although the division of the frænum linguae is usually looked upon as a trifling operation, it is one that should not be lightly performed, and upon every common occasion. Petit relates two instances, in which death followed from the frænum being so much loosened, as to permit the tongue to fall backwards into the pharynx, and suffocate the patient. Other cases are recorded of fatal hemorrhage from wounds of the ranine arteries and veins. To guard against accidents of this description, the operator should use a pair of probe-pointed scissors, and take

care to direct their points downwards, and divide no more of the frænum than is absolutely necessary. Dr. Dewees, whose experience in the treatment of the diseases of infants, is equal, perhaps, to that of any practitioner living, objects to the use of scissors in the division of the frænum linguæ, and employs, instead of them, a common gum lancet. He has never met with a case in which the tongue was swallowed, or of hemorrhage, from the division of the ranine arteries, or other vessels. Hence it may be fairly inferred that such accidents must be exceedingly uncommon. According to the same practitioner, there are two causes that may give rise to an operation, the one an adventitious membrane, which pursues the natural frænum throughout its whole course, and even continues beyond the frænum, and ties the tongue so completely down, that the child cannot raise the tongue, or carry it beyond the lips—the other, an actual shortening and thickening of the proper frænum itself.

See *Petit's Traité des Maladies Chirurgicales*, tom. 3, p. 260—*Burns' Surgical Anatomy of the Head and Neck*, p. 264—*C. Bell's Operative Surgery*, vol. 2, p. 28.

SECTION IV.

Enlarged Tonsils.

ENLARGEMENT of the tonsils is very common among scrofulous children, and arises from exposure or repeated attacks of catarrh and sore throat. Sometimes, however, the disease is slowly induced without being preceded by pain, swelling, or any of the characteristics of acute inflammation. If suffered to remain for any length of time, the tumours occasionally attain so large a size as to interfere materially with respiration and deglutition. Persons troubled with this disease, have a peculiar hoarse, husky, or croaking voice, and when labouring under cold, wheeze excessively.

Treatment of Enlarged Tonsils.

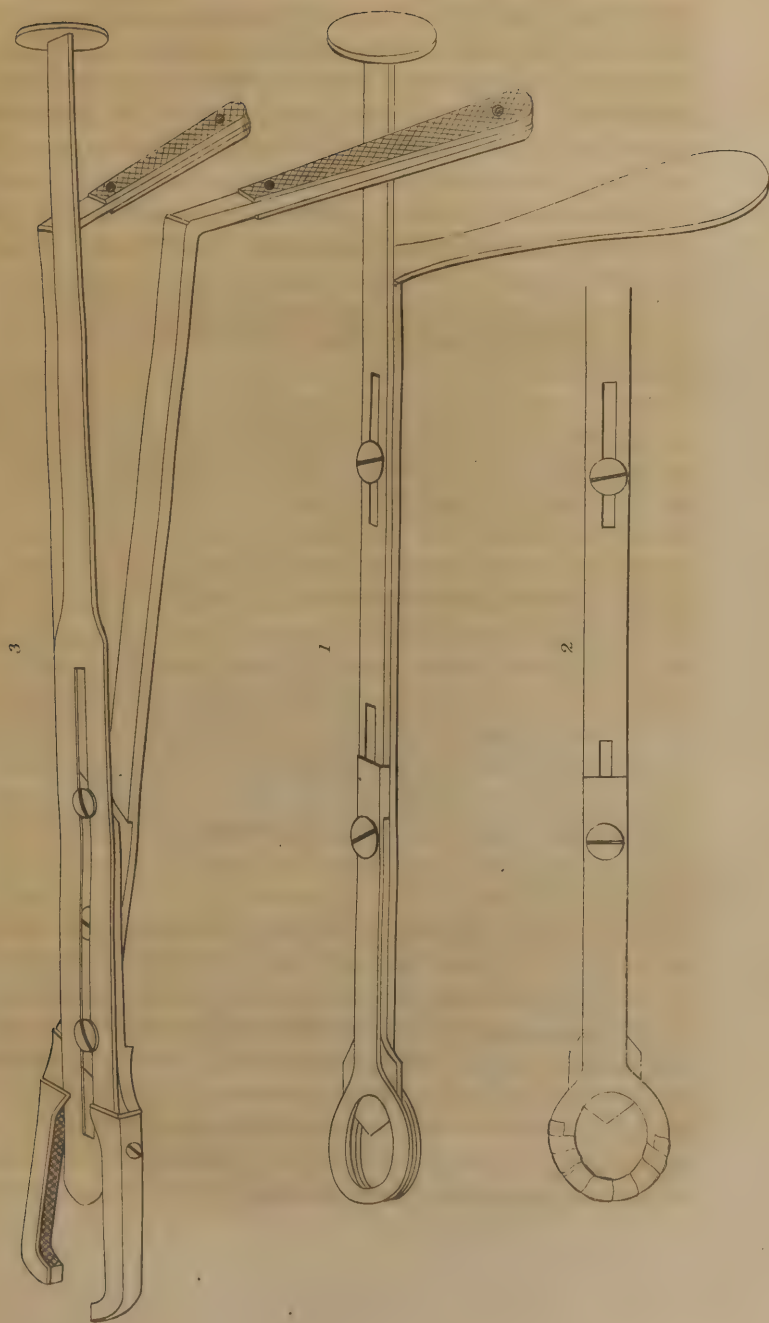
The *knife* and *ligature* have been frequently employed in the removal of enlarged tonsils. To the latter the preference is usually given, inasmuch as there is no risk of hemorrhage, a consequence sometimes apt to follow the use of the knife even when employed with the utmost caution. Formerly the ligature was suffered to remain upon the enlarged gland for several days, or indeed until the tumour sloughed away, and from this practice great irritation about the fauces, tongue, and mouth, ensued. To obviate these inconveniences, Dr. Physick first sug-

gested the following mode of practice. The operator takes a double cannula, about four inches long, and passes through it, doubled, a piece of soft, flexible iron wire, one twenty-fourth part of an inch in diameter, secures one end of the wire to an arm of the cannula, and permits the other end to project about five or six inches beyond the opposite barrel of the instrument. The cannula being thus armed, the loop of wire is spread out to a sufficient extent to pass over the tumour, and is bent a little to one side, that it may with the greater facility approach its base. An assistant holds down the patient's tongue with the handle of a large spoon, while the operator conveys the wire over the base of the tumour, and taking hold of its projecting end draws it loosely in order to ascertain whether it is properly fixed. Finding this to be the case, and that the uvula is not included, the end of the wire is then seized with a pair of flat pliers, drawn as firmly as possible, and secured by wrapping it around the remaining arm of the cannula. The wire, thus applied, should be permitted to remain on the tonsil *twenty-four hours*, and then disengaged in the following way. The cannula being firmly held with one hand, the other is employed in loosening the end of the wire from the arm of the instrument; having accomplished which, the surgeon straightens the wire with the pliers, and pushes it backwards until it is removed from the tonsil. In a few days the tumour drops off entire, or in fragments, and the ulcer left heals without difficulty.

For several years Dr. Physick pursued the above practice; but experience taught him that although the operation, thus modified, was free, in a measure, from the inconveniences of the old method of using the wire, there were yet objections to the practice which he had not anticipated. In particular, he found that, in some instances, profuse ptyalism, swelling of the throat, difficulty of breathing and swallowing, (sometimes followed by ulceration of the soft palate and fauces,) were induced. Of late years, therefore, he has abandoned the ligature, in toto, and employed the knife. The instrument he uses was originally invented by him for truncating the uvula. "In the operation for cutting off the uvula, Dr. Physick has, until very lately, used scissors; but being unable to complete the operation by one application of that instrument, several have been necessary to effect the

division of the part. To obviate this difficulty, he determined to try the old instrument, as modified and represented by Benjamin Bell, in his *System of Surgery*. He found, however, that although he could divide with that instrument the greater part of the uvula, a portion of the membrane that covers the back part of it was not always divided, making the use of the scissors necessary to cut it through. To remedy this inconvenience, he caused an instrument to be made having two plates instead of one, between which the knife was passed; but still the same difficulty was experienced in cutting through the membrane on its posterior part. He then thought of wrapping a strip of waxed linen over the semicircumference of the opening, to support the membrane until it should be divided by the knife. Thus constructed, the instrument answered the purpose completely, and cut through the whole substance of the part in an instant. Dr. Physick has since used an instrument of similar construction, for the removal of scirrhus tonsils. He finds it easy to cut off the whole, or any portion that may be necessary, of the enlarged tonsil in this manner. The operation can be finished in a moment of time. The pain is very little, and the hemorrhage so moderate that it has not required any attention in four cases, in which he has lately performed it. The size of the perforated end of the two plates, and of course that of the knife, must be larger in the instrument for extirpation of the tonsils, than in that for truncation of the uvula.”* The construction of this instrument will be better understood by examination of Plate I. fig. 1 and 2. In a subsequent account of Dr. Physick’s instrument, it is remarked, that “occasionally there is some difficulty in passing the circular aperture in the extremity of the two plates completely and speedily over the tonsil to its base. In such cases the operation may be much facilitated, by using a forceps with a lunated extremity, to which teeth are adapted, invented by Dr. Physick, by means of which the tonsil may be seized and drawn through the aperture to any distance that may be deemed proper, when its extirpation can be immediately effected. It may not, however, be improper to observe that, under ordinary circumstances, the aid of the forceps

* *American Journal of Med. Sciences*, Feb. 1828.



is altogether unnecessary. The forceps is about seven inches long, curved near its extremity, which is lunated and armed with teeth.”*

Having experienced more or less difficulty in the removal of enlarged tonsils—owing, chiefly, to the number of instruments, such as spoons, hooks, forceps, &c., required—it occurred to me that an instrument might be contrived that would answer the purpose of all these—by keeping down the tongue, holding the gland firmly, and separating it nearly at the same moment. Such I accordingly projected, and ordered made, and upon trial found to answer my most sanguine expectations. For several years past I have used it, in a number of instances, and have seen it used by others, and can, therefore, speak of it decisively. It consists of a pair of forceps nine inches long, the eighth of an inch thick, half an inch broad, when shut, with extremities an inch and a half long, slightly serrated and somewhat curved, including, when closed, an oval space a quarter of an inch wide, and terminating, at the other extremity, in handles which stand off obliquely from the shafts of the instrument. A knife, or blade, the length and breadth of the forceps, rounded on its cutting edge, and having a button placed perpendicularly to its axis on the opposite extremity, works backwards and forwards by means of a groove, to the extent of an inch and upwards, between the blades of the forceps, to one of which it is secured by screws. A sheath upon each end of the forceps, to keep the knife from starting off the moment it touches the tumour, completes the instrument.† See Plate I. fig. 3.

To apply the instrument properly, it will only be necessary to introduce it into the patient's mouth with the blades closed and resting flat upon the tongue, which is thus kept depressed. The instrument is then turned on its edge, still resting on the tongue, its blades expanded, placed fairly around, and completely *behind* the tumour, which is then seized, and firmly held, while the thumb, resting on the button-like extremity of the knife, pushes it forwards and instantly separates the enlarged tonsil, which is immediately brought away in the grasp of the forceps.

* Am. Journal of Med. Sci. May, 1828.

† This instrument, as well as Dr. Physick's for the same purpose, was manufactured by Mr. H. Schively.

To prevent any portion from being left, or the tumour from hanging by a narrow neck, the surgeon should see that the knife reaches to the very extremity of the forceps, and should be sure that the whole of the tumour is fairly within the grasp of the instrument. The instrument may be applied indifferently to either tonsil—care being taken always to place the surface of the forceps on which the *knife* rests to the base of the tumour.

Profuse hemorrhage sometimes follows the excision of the tonsils. The surgeon, aware of the possibility of this, should take care not to apply the knife too near the base of the tumour. More than twenty years ago, I cut off an enlarged tonsil with scissors from a medical student, now a respectable practitioner at Bedford, Pennsylvania, and had great difficulty in preventing the hemorrhage from terminating fatally. Wisemen and Moscati point out danger from another source—the falling of the tonsil backwards, when partially cut, upon the rima glottidis—and relate cases of suffocation from that cause.

See Desault's Works, by Smith, vol. 1, p. 193—Sharp's Treatise on the Operations of Surgery, p. 199, edit. 9—Chevalier's New Mode of Tying Diseased Tonsils, in vol. 3, p. 79, Medico-Chirurgical Transactions—Dorsey's Surgery, vol. 1. p. 422—The Double Cannula and a Wire, recommended in the Operation of Extirpating Scirrhus Tonsils, and Hemorrhoidal Tumours, by Philip Syng Physick, M. D. in vol. 1, p. 17, of the Philadelphia Journal of the Medical and Physical Sciences—Case of Obstinate Cough, occasioned by Elongation of the Uvula, in which a portion of that organ was cut off, with a Description of the Instrument employed for that purpose, and also for Excision of Scirrhus Tonsils, by Philip Syng Physick, M. D., Professor of Anatomy in the University of Pennsylvania, in Journal of Medical Sciences, for 1828—Description of a Forceps employed to facilitate the Extirpation of the Tonsil, and invented by P. S. Physick, M. D. Id. 1828.

SECTION V.

Elongation of the Uvula.

THE uvula, from colds or other causes, is frequently enlarged or elongated. If it continues so for any length of time, troublesome irritation about the epiglottis, nausea, vomiting, and even hæmoptysis, and phthisis pulmonalis may be induced.

Treatment of Elongation of the Uvula.

To obviate some of these consequences, an operation has been practised from time immemorial—the excision or amputation of the uvula. This may sometimes be performed by a hook and common scissors, or by the particular scissors described and engraved by Mr. Samuel Cooper, in his “First Lines of the Practice of Surgery.”* These are so contrived, as, by means of a transverse projection from one of the blades, to support the uvula, and keep it from falling backwards at the moment the operator attempts to divide it. Even with this instrument, however, the operator is extremely apt to fail, or else divide a part only of the uvula, which is immediately drawn upwards, and lodged behind the velum in such a way as to render it difficult afterwards to remove it. It will be better, therefore, to resort to Dr. Physick’s instrument for the removal of the tonsils, or to the one I have recommended for the same purpose. The instrument, however, should be made smaller for the uvula than the tonsil.

Mr. Benjamin Bell states that he has known very profuse hemorrhage to follow amputation of the uvula. I have often

performed the operation, but never met with an accident of the kind.

The real importance of amputation of the uvula has only been estimated of late years, and it remained for Dr. Physick to point out the cases to which it was peculiarly adapted. He had met with several instances of troublesome cough, followed by emaciation of the whole body, sometimes by hemorrhage from the lungs, and eventually phthisis pulmonalis, which were produced apparently by elongation of the uvula. This determined him to try the effect of an operation in the early stages of the disease, and the result was favourable in the extreme—the cough and other urgent symptoms disappearing almost immediately, and the patients recovering perfectly in a very short time. From experience I can speak confidently of the value of the remedy, and have reason to believe that it seldom fails unless too long delayed.

SECTION VI.

Fissure of the Palate.

A DEFICIENCY of the soft palate, or rather a division of it, either conjoined with or independent of, a cleft in the palate bones, is a congenital malformation, almost as common as that of hare lip, with which, indeed, it is not unfrequently associated. Like hare lip, too, it not only, during infancy, interferes with the suction of the child, but in after life impedes deglutition, and in many instances renders articulation nearly unintelligible. Many patients, indeed, fall a sacrifice to the disease, from extraneous matters getting into the windpipe, and bronchiæ, and laying the foundation of pulmonary affections. At other times, the patient suffers extremely from fluids, and even solids, being thrown from the stomach, or mouth, into the nares, where they excite sneezing, great irritation, and even ulceration.

Treatment of Fissure of the Palate.

Although surgeons had long been acquainted with the existence and nature of malformation of the palate, few, if any, attempts had been made to obviate the deformity, until Roux, an eminent Parisian surgeon, drew the attention of the profession to an operation which he denominated *Staphyloraphy*, and by which he had succeeded in *reuniting* the edges of the soft palate in twelve cases. These cases were published in 1825.

Since that period, Roux has performed, with more or less success, the operation *fifty-one times*. Out of this number, but one case has been followed by death.* It occurred in a young female, who, on the evening of the operation, was seized with inflammation of the throat, and, subsequently, with that of the chest, and died on the eighth day. Roux's operations were soon followed by those of Græfe, Dieffenbach, and others, on the continent of Europe; by Alcock, in Britain; and, subsequently, by Warren, Stevens, and Hosack, of our own country.

The first case upon which Roux performed his operation, was that of a Canadian student, attending lectures in Paris. Before cutting away the edges of the soft palate, as in hare lip, Roux determined to introduce three stout ligatures into the border of the palate, and at regular distances from each other. To accomplish this, he employed a small, curved needle, fixed in the *porte-aiguille*; passed it through the palate about a quarter of an inch from its edge, then seized its point with the common dressing forceps, and drew it, together with the ligature, forward. In like manner the other ligatures were introduced, always carrying the needle from behind forwards. The edge of the palate was then cut away by the knife and curved scissors, to the extent of a line in thickness. The same operation having been performed on the opposite side of the palate, the edges of the wound were approximated by drawing each interrupted suture, tying it, and then cutting off the ends of all the ligatures. To prevent the first knot from slipping, it was held by a pair of forceps, called *pince à anneaux*, until the second knot could be secured. The patient was kept on low diet, and not permitted to speak. At the end of the third day, the two upper ligatures were removed, and, on the fourth day, the remaining ligature. Lest the reunion, which had taken place throughout each edge, might be endangered, the patient was not permitted to speak until the *eighth* day. By that time, however, the adhesion was complete, the cicatrix firm, and the deformity, with all its inconveniences, namely, imperfect articulation, difficult deglutition, &c., completely removed. Roux's object, in *first* inserting the ligatures, and *subsequently* paring

* *Lancette Française*, 1830.

the edges of the palate, was to prevent the hemorrhage from interfering with the operation by obstructing the view of the parts, in which view most surgeons will probably concur with him.

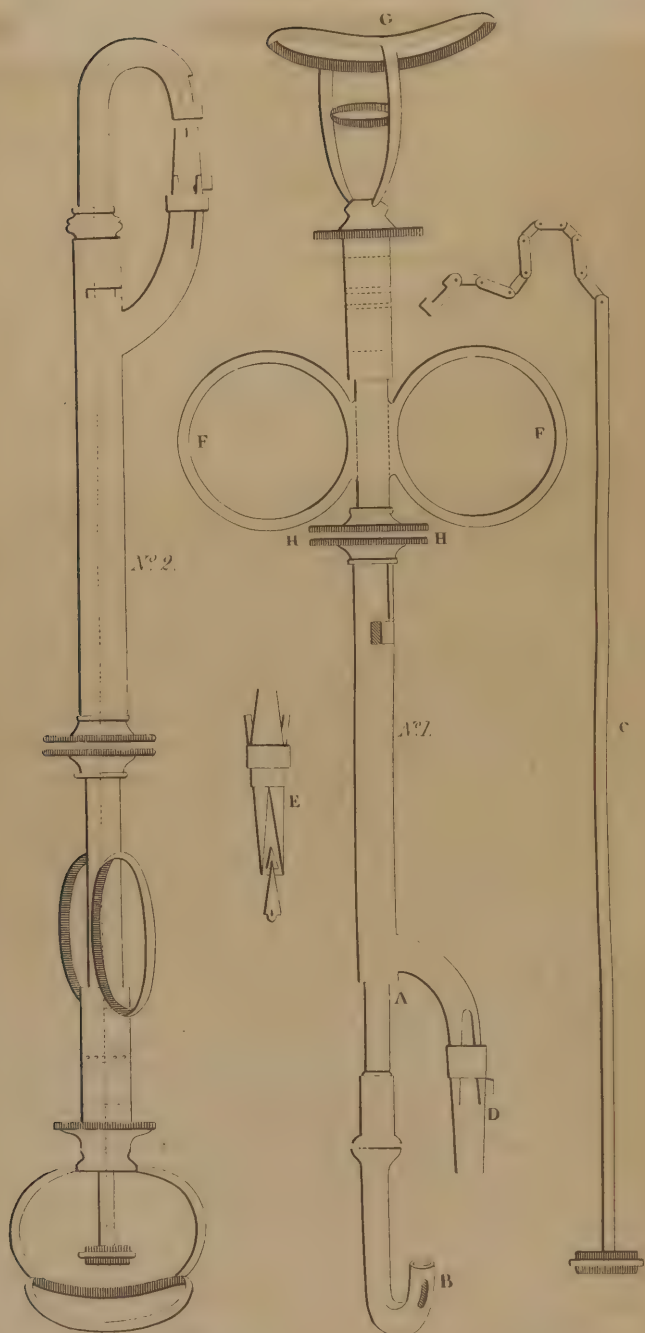
Professor Warren, of Boston, was the first to perform, there is reason to believe, staphyloraphy, in the United States. The ligatures were introduced by an instrument, apparently very simple, resembling a common dissecting hook in form, with an eye near its extremity, through which passed a triple thread of strong silk. "The palate was pierced by the hook at one-third of the length of the fissure from the upper angle of the wound, so as to include about three lines of the edge of the soft palate. The eye, with the ligature, being seen, the latter was seized with a common hook, and drawn out. The eyed-hook was then drawn back, turned behind the palate, and the other edge transfixed in a similar manner." Two other stitches were made in a similar way, the edges of the palate drawn together, and the knots tied without difficulty with the fingers. Unlike Roux's operation, the edges of the palate were cut away by a bistoury previous to the introduction of the ligatures. The patient recovered perfectly, and in a short time. In a second operation of the kind, performed by Dr. Warren on a boy during the prevalence of influenza, the inflammation, owing to that disease, was so high as to require the ligatures to be removed. The operation consequently failed, although adhesion had taken place, but was afterwards destroyed by the fingers of the boy, in attempting to relieve his cough. Dr. Warren has improved, subsequently, his instrument, by making the *point removable*, so that the ligature and point can be drawn out together.

The operation of staphyloraphy was performed by Dr. Stevens of New York, in 1826. The ligatures were introduced by a curved needle attached to a handle by means of a screw, and the edges of the velum supported by forceps, afterwards dissected away by a cataract knife. Reunion speedily took place, and by the tenth day the patient returned home with the voice much improved, but not so perfectly restored as in some of the cases reported by Roux.

But my friend Dr. Alexander E. Hosack of New York, an excellent surgeon, has paid more attention, perhaps, to staphy-

loraphy than any one else in the United States. In a memoir by him on the subject, published in 1833, at the request of the Medical Society of the City and County of New York, interesting observations are made, cases reported, and ingenious instruments invented by himself, described, which ought to be familiar to every one before undertaking one of the most difficult operations in surgery. Under these impressions I shall insert a short account of Dr. Hosack's instruments, which, together with the plate and explanation of them, cannot fail, I hope, to render them perfectly intelligible.

"It occurred to me," says Dr. H. "that as the greatest difficulty and delay were experienced in the passing of the ligatures,—arising both from the irritability and constant motion in the palate, as well as the unavoidable disposition to swallow,—an instrument might be constructed, calculated to lessen the inconvenience, as well as shorten the time. I consequently caused one to be made, as represented in the plate, and which I have since improved, and find perfectly to surmount the objections. In the application of this instrument, the surgeon is enabled to fix his eye on the part through which the ligature is to pass; the palate is at the same time, and with the same instrument firmly held, so as to avoid displacement, by any involuntary motion that may occur. The time required for passing each needle is but an instant, and it can always be accomplished with the greatest accuracy, as regards the relative distances, as well from the borders as from each other. This point being determined, I directed my attention to the second step of the operation, which is properly that of excision.—The straight bistoury, and the ordinary angular scissors, are as yet, the only instruments used for that purpose.—In offering objections to them, I trust I may escape being censured for a great desire of finding fault, as well as from any unreasonable prejudice, in favour of invention. Having performed the operation, I feel myself at liberty to suggest an alteration in the scissors, which, while it embraces all the advantages possessed by the above instrument, offers facilities to the surgeon. He is at once enabled to follow with his eye every movement of the blades, until the borders are entirely separated, and thereby control the extent and amount of substances to be removed. Two scissors will be required—one for either side, six inches in length.



When viewed in profile, their form inclines to that of the letter *f*. The blades form the junction to the point, and curved laterally and forwards, so as very much to resemble the beak of an eagle, or any other bird of that class, and which, when applied to the palate, adapt themselves to the arched sides of the cleft. No. 1, represents a front view of the instrument for passing the needle. A, the hollow shaft with the curved extremity. B, an aperture, through which the eye is to direct the head of the needle into the thimble—C, the rod drawn out, with the chain, and thimble-like extremity attached to it. D, the bayonet fixture, adjusted upon the shaft, with the forceps for receiving the needle. E, a profile view of the forceps holding the needle. F, the rings for receiving the first and second fingers of the right hand. G, the guard upon which the thumb, of the same hand, is to rest. H, the wheel, or the part of the bayonet fixture, by which its motions are controlled. The index finger of the left hand is to be placed upon it; by which means it is turned, until brought opposite to the crook, in which the needle is concealed; it is then to be pushed quite up, holding the palate between. The thumb, of the right hand, is at that moment to glide through the guard upon the button of the rod, which is to be thrust forward, driving the needle, armed with the ligature, into the forceps; the bayonet fixture is then drawn back and turned off, carrying the needle with it.—No. 2, a profile view of the same, in the act of receiving the needle.” See Plate II.

I have reason to believe that the operation of staphyloraphy has been performed, likewise, by Dr. P. Metteaux, an eminent surgeon of Virginia, as I recollect to have seen, some years ago, an ingenious instrument devised by Dr. M. for that purpose, in the hands of the maker—the celebrated Schively. It may have been performed by other surgeons in America; but if so I am not aware of the fact.

An interesting case of extensive *wound of the soft palate*, cured by drawing together with sutures the divided edges, is reported in the tenth volume of the *American Journal*, 1832, by Dr. Wells, of Columbia, South Carolina. “A lad, aged five years,” says Dr. Wells, “was running with one end of a piece of reed cane, a foot long, and about an inch in diameter, and square across at the extremities, in his mouth. He fell forward; the end of the cane coming in contact with the ground, it was

thrust violently into his throat. I saw him very soon after the accident happened. There were two lacerated incisions, extending from the centre of the back part of the bony arch of the mouth, backwards and outwards on each side, something more than an inch, and terminating within less than half an inch of the inferior margin of the velum palati. The soft parts were cut, or torn through, making a triangular flap, the apex of which had fallen forwards and downwards, and hung dangling upon the root of the tongue, leaving the posterior nares and pharynx fully exposed. There was considerable hemorrhage, and the child and friends were extremely alarmed. A short common surgeon's needle was heated in the flame of a lamp, bent to a proper curve, armed with a ligature, and confined in Dr. Physick's forceps for taking up deep-seated arteries. The patient was placed upon a table and held by assistants. The mouth was kept open by a large cork placed between the back teeth, and his tongue depressed with a spatula. The needle was passed through the apex of the flap, and then through a corresponding portion of the mucous membrane, and cellular substance on the roof of the mouth, and the ligatures tied by the common stems for such operations when the fingers have not access. It was not attempted to insert more than one suture, although this did not bring the parts into exact contact; but the swelling which supervened in the course of a few hours, as was anticipated, fully obviated that difficulty. He was kept as quiet as possible—not allowed to swallow any thing for the first four days, except a little milk and toast water, and then as seldom as practicable. At the end of this period adhesion was found to have taken place at every point. There is not the slightest deformity of the parts remaining. There was considerable difficulty in this little operation, from the struggles of the patient and the contracted space left for us to act in—the mouth being already pretty well occupied by the apparatus for keeping it open and depressing the tongue; indeed, without the above instruments, or others equivalent, it would have been found impracticable either to pass the ligature or to tie it.”

On Staphyloraphy, consult *Memoire sur la Staphyloraphie, ou Suture du voile, du Palais, par Phil. Jos. Roux, Paris, 1825—On an Operation for the Cure of*

natural Fissure of the soft Palate, by John C. Warren, M. D., Professor of Anatomy and Surgery in the Medical Institution of Harvard University—in *American Journal of Medical Sciences*, vol. 3d, 1828.—*Staphyloraphy, or Palate Suture, successfully performed*, by A. H. Stevens, M. D., Professor of Surgery, in the College of Physicians and Surgeons, New York, in *North American Medical and Surgical Journal*, Vol. 3d, p. 233, 1827—*A Memoir upon Staphyloraphy, with Cases and a Description of the Instruments requisite for the Operation*, by Alexander E. Hosack, M. D., one of the Surgeons of the Marine Hospital, New York, 1833.

SECTION VII.

Epulis, or Tubercle of the Gums.

THIS disease, like polypus of the antrum, sometimes assumes a malignant form, and, involving the teeth and adjoining parts, is soon beyond the reach of surgery. This will show the propriety of attending, in the commencement, to every small tumour about the gums, however harmless may be its appearance. Any one, indeed, who will peruse the melancholy but instructive cases detailed by Messrs. John and Charles Bell, the only writers who appear to have taken a deep interest in the subject, will need no further proof of the importance of the disease.

Epulis generally sprouts from the sockets of the incisor teeth of the upper or lower jaw. The teeth themselves are frequently sound and perfectly white, and in many instances long before the tumour is perceptible, are loosened and carried above the range of the adjoining teeth. In other cases, a small seed-like excrescence is seated upon the gum between the teeth. This remains stationary for months together, or it grows so slowly, and is attended with so little inconvenience, as scarcely to attract the patient's attention. At last it loses its hard and solid feel and gristly appearance, becomes soft and rugged on the surface, bleeds upon the slightest touch, and throws out a prolific fungus. After this, no bounds are set to the increase of the tumour, the teeth are successively displaced, the lymphatic glands and other soft parts in the neighbourhood contaminated, the mouth filled with a mass of disease so large as to embarrass the breathing and swallowing, the texture of the bones of the face or lower jaw broken up, and the patient eventually destroyed by hemorrhage, suffocation or irritation.

Treatment of Epulis.

Extirpation of this tumour, in its very incipency, is the only remedy likely to effect a permanent cure. In performing this operation the surgeon will find it necessary to provide himself with forceps and other instruments, for pulling teeth, one or two short and very strong scalpels, two or three fine watch-spring saws, tenacula, sponges, a vial of the muriated tincture of iron, lint, &c. If there is strong evidence of the tumour having originated deep among the sockets of the teeth or in the cells of the bone, the teeth surrounded by the tumour, however, perfect they may appear to be, must be sacrificed, and not only the teeth, but the alveolar processes also. The cut in this case should be made with one of the fine saws perpendicularly through the bone on each side of the tumour. By these means it will be so loosened as to be easily detached with a pair of strong forceps. The hemorrhage that follows is commonly very profuse, but may be speedily arrested by dipping a piece of lint in the muriated tincture of iron, and thrusting it to the bottom of the wound (placing above the lint a bit of cork or some elastic substance to support the lint,) closing the patient's jaws, and securing them by a bandage. In twenty-four or thirty-six hours the lint may be removed, and if necessary the application of the muriated tincture renewed at each succeeding dressing; or the lunar or vegetable caustics may, with the same view, be applied. By adopting this plan, (the one suggested and practised by Sir Charles Bell,) I have in several operations of the kind succeeded perfectly. In other instances, where I have merely removed the tumour with the knife and caustic, it has invariably returned.

See *John Bell's Principles of Surgery*, vol. 3, p. 178—*Charles Bell's Surgical Observations, being a quarterly Report of Cases in Surgery*, vol. 1, p. 413—*Gibson on Bony Tumours, in the Philadelphia Journal of Medical and Physial Sciences*, vol. 2, p. 145.

CHAPTER III.

DISEASES OF THE NECK.

THE importance of the diseases of the neck can be fairly estimated only by those who possess an accurate knowledge of the structure and functions of its numerous and complicated organs. The student should use, therefore, in prosecuting his anatomical investigations of these parts, more than ordinary diligence. Besides the great blood vessels, and nerves of the neck, the pharynx, œsophagus, larynx, trachea, thyroid gland, are subject to accidents and diseases of the most pressing and grievous nature. Wounds of these different parts have already been considered,* but it still remains to treat of several other affections. These are the lodgement of foreign bodies in the pharynx and œsophagus, foreign bodies in the larynx and trachea, ulceration of the glottis, bronchocele wry-neck, &c.

SECTION I.

Extraneous Bodies in the Œsophagus.

IT frequently happens that persons, from hurry or voraciousness, in attempting to swallow a large piece of beef, tripe, gristle, cheese, bread, and other similar substances, are choked, and in

* See Vol. I. p. 106.

danger of suffocation. In other instances, fish bones, chicken bones, pins, and needles, pieces of coin, stick in the pharynx or œsophagus, and excite irritation in proportion to their size, shape, &c. There is reason to believe, in most cases of the kind, that the difficulty of breathing which ensues, arises from the spasmodic action of the muscles of the glottis by which this chink is preternaturally constricted. Death may follow from this cause, or from the foreign body distending the œsophagus to such a degree, as to press upon the trachea and interrupt the passage of air, or the patient may die at some subsequent period from inflammation or gangrene induced by the continued pressure of the extraneous body, or injudicious and violent attempts to remove it.

Removal of Extraneous Bodies from the Œsophagus.

When a large substance is swallowed, it generally sticks in the pharynx or between the cornua of the os hyoides and thyroid cartilage, and often may be seen or reached with the finger. In like manner, fish bones and other small and irritating bodies, when similarly situated, may be removed by a pair of forceps, or by tickling the fauces with a feather, or by holding a solution of tartar emetic in the mouth. These last, by exciting vomiting, have the effect of expelling the foreign body. There are, however, several regular instruments well adapted to the removal of articles lodged in the throat; but the surgeon, if suddenly called to a patient apparently choking and in imminent danger of his life, should waste little time in searching for these instruments. On the contrary, he should seize upon any thing that happens to be in his way, calculated to dislodge the morsel—such as a horse-whip, the handle of a spoon, a rattan, &c. As a general rule, digestible articles, provided they are free from asperities, should be forced into the stomach by the *probang*—a whalebone rod, having a round piece of sponge fixed upon one end and a blunt hook upon the other. This instrument (its sponge being previously softened a little) may be easily introduced by thrusting it against the back part of the pharynx. The

sponge imbibing freely the moisture of the passage fills it up entirely, and carries the body before it, unless very firmly fixed.

Copper coins, and all sharp or ragged bodies, should, if possible, be extracted by the gula forceps, probang hook, or by a hook made of a piece of bell wire, upon the spur of the occasion. Sometimes a rod of whalebone, with numerous loops of thread or horse hair attached to one end of it, answers an excellent purpose, by entangling fish bones and other sharp bodies. After extraneous substances have been pushed into the stomach, the patient should take, for several days successively, purgatives and mucilaginous draughts, to promote their passage through the intestines. For several years Dr. Physick has been in the habit of prescribing *rice*, and other similar articles, in large quantities, with a view of defending the coats of the stomach from the action of foreign bodies—and usually with great success. Needles and pins that have been swallowed, not unfrequently perform extensive journeys throughout the body, and at last are discharged through the skin.

Dr. Henry Bond,* of this city, has made a very ingenious improvement on the common gullet forceps. That instrument, as is well known, is defective, chiefly, on account of the blades closing upon each other with a *flat* surface, thereby leaving, necessarily, four sharp or angular edges, well calculated to *pinch* the lining membrane of the œsophagus. To obviate this inconvenience and danger, Dr. Bond's forceps have been beveled off from the edges to the centre of the inner surface of each blade, so as to produce two convexities, or ridges, which are slightly serrated, and meet each other at a single line. Besides holding the foreign body with sufficient firmness, the narrow rough line allows the article, contained in its grasp, "to *vibrate* freely and to assume a position nearly parallel to the blades."

A case occurred, some years ago, in the Eastern States, where a fish hook, with part of the line attached to it, was swallowed. In the attempts to remove it, by pulling upon the line, the hook became fixed in the side of the œsophagus. After much difficulty, it occurred to an ingenious person present, that the proper mode to extricate the hook would be, to take a large leaden

* Observations on the Removal of foreign Bodies lodged in the Œsophagus, by Henry Bond, M. D., in North American Med. and Surg. Journal, for October, 1828.

bullet, drill a hole in its centre, pass the line through it, and let it be swallowed by the patient. The experiment was accordingly tried, and with success—the bullet, by its weight, first disengaging the hook, and then its point being afterwards brought in contact with the lead, was prevented from sticking again in the œsophagus, in the act of drawing upon the line, so that both the bullet and hook were drawn out together. These particulars were communicated to me formerly, by a very intelligent student, Dr. Bradley of Maine; but I have forgotten the name of the surgeon concerned in the case.

The operations called *pharyngotomy* and *œsophagotomy* should seldom, I conceive, be performed; but in order to sustain the patient's breathing, during the attempts to remove a large body from the pharynx or œsophagus, it may possibly become expedient to resort to bronchotomy or tracheotomy, as will be explained hereafter.

SECTION II.

Stricture of the Œsophagus.

THE Œsophagus, like the urethra, is sometimes the seat of stricture, either of the spasmodic or permanent kind. Nervous and hysterical patients are most subject to the former disease, and the latter may occur in patients of every variety of constitution. Occasionally, the two affections are combined. Permanent stricture is met with in two or three different situations. Its most common seat, however, is immediately behind the cricoid cartilage, or in the commencement of the Œsophagus. The contraction is generally found to consist of a fold of the internal membrane of the tube. In advanced cases of the disease, the whole cavity of the Œsophagus is often entirely closed, and to a considerable extent, arising, probably, from the effusion of lymph, or from the glands of the passage assuming a scirrhus or cancerous action. The symptoms of permanent stricture of the Œsophagus, are difficulty of swallowing in proportion to the duration of the disease, pain in the stomach, nausea, troublesome eructations, pain in the fauces, and extending thence along the base of the skull. In addition to these symptoms, the patient often finds it impossible to pass either solids or fluids in the smallest quantity, and as a necessary result, emaciation ensues. Some patients, however, can readily swallow fluids, especially when sipped in small quantity; others find it easier to swallow solids.

The causes of this disease are very obscure. In most instances, there is reason to believe, that the permanent stricture is the result of inflammation, however induced. By Dr. Burwell, an intelligent practitioner of Buffalo, I am informed that several cases of the disease have occurred in his neighbourhood, from drinking of the liquor of pearl-ash, kept by most housewives to lighten their bread, and generally deposited in the

same closet with spirits, for which it has been mistaken. Similar cases have been reported by Sir Charles Bell*—from the accidental swallowing of soap-lees.

A disease very opposite in character to stricture of the œsophagus, is sometimes met with—paralysis of the œsophagus. This occurs, for the most part, in old people, and frequently as a concomitant of palsy in other parts of the body. The power of the muscular fibres of the œsophagus being impaired or lost, the patient can take neither solids nor fluids, and, unless speedily relieved, must die of inanition.

Treatment of Stricture of the Œsophagus.

Bougies, either alone or armed with lunar caustic, may be considered the only remedies for this disease. To ascertain the situation and extent of the stricture, a soft wax bougie is employed. This may be readily introduced, by directing the patient to draw back his tongue and imitate the action of swallowing. If the stricture is ascertained, from the resistance and the impression made on the end of the bougie, to be a permanent one, the caustic bougie may be immediately carried down, and kept in contact with the stricture three or four minutes. In two or three days the operation may be repeated, and kept up occasionally until the stricture is destroyed, or until a common bougie will readily pass.

For the relief of *spasmodic* stricture of the œsophagus, I have often employed the unarmed bougie, and with the happiest effect. In such cases, also, the internal use of valerian, camphor, opium, ether, will be found highly serviceable.

Paralysis of the œsophagus may be sometimes removed by electricity. To nourish the patient during the cure, the gum elastic œsophagus tube is essential. The surgeon should take

* Surgical Observations.

care that fluids conveyed through it are not too hot, otherwise the stomach may be scalded. From this cause, several patients have lost their lives. When the œsophagus, from stricture or any other cause, is so completely closed that a bougie or gum elastic tube will not pass, the patient must be nourished by glisters.

The cardiac, as well as other portions of the œsophagus, is not unfrequently the seat of scirrhus and cancerous affections. The progress of the disease is generally very slow and gradual. Often it is mistaken for common stricture of the œsophagus, and treated accordingly; by which the symptoms are aggravated and ulceration hurried on. In many instances, the disease extends to the stomach, all the coats of which, as well as those of the œsophagus, are indurated and often ulcerated to a great extent. Such affections are, of course, incurable. The celebrated Napoleon died of cancer of the stomach.

Tumours situated between the trachea and œsophagus, enlargement of the thyroid gland, indurated lymphatic glands, aneurism of the aorta and other affections, may, by pressure, involve the œsophagus, and generally admit of no relief.

SECTION III.

Extraneous Bodies in the Larynx and Trachea.

DURING the act of deglutition, articles of food, instead of passing into the œsophagus, are sometimes suddenly diverted from their course, and thrown into the glottis. An instantaneous, violent, convulsive cough, and laborious respiration, are the immediate consequences. If the extraneous body should be detained in the glottis, death speedily follows from suffocation; but in many instances, the body passes entirely through the chink of the glottis into the trachea, or else it is forced by the cough into the laryngeal pouches. In either case, the patient is saved for the time, or eventually may recover. The lodgement, indeed, of a morsel in the sacculus laryngeus, is comparatively harmless, and the irritation occasioned by its presence soon subsides. I have known extraneous articles to remain in these cavities for years, without inconvenience, and indeed without the patient being sensible of their presence. When, however, the substance descends into the trachea, incessant irritation is kept up, and, although the patient, even under these circumstances, may survive for weeks, months, or years, yet in the end, unless relieved by an operation, he is sure to die—from effusion into the cells of the lungs, from phthisis pulmonalis, &c.

Removal of Extraneous Bodies from the Larynx and Trachea.

It is very seldom that the surgeon succeeds in extracting by instruments an extraneous body lodged even in the *vicinity* of the larynx; of course, the removal of it from the larynx or trachea, by such means, is out of the question. But to obviate instantaneous suffocation, or to remove the foreign body, an operation may be required.

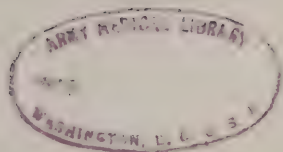
Laryngotomy and tracheotomy, (so denominated according

as the larynx or trachea may be the seat of the operation,) are both occasionally required. The former, however, is best adapted to the removal of extraneous bodies, and is performed in the following manner. The patient being laid on a table, with his head supported by a pillow, and thrown moderately backwards, the surgeon feels for the membranous space situated between the thyroid and cricoid cartilages, makes a perpendicular incision about an inch in length through the integuments, platysma-myoides, and between the sterno-thyroidei and sterno-hyoidei muscles. Any vessels that may have been divided, are next carefully secured, and the bleeding having entirely ceased, it only remains to push the knife through the crico-thyroid membrane, when the extraneous substance will be either immediately thrown out or presented at the wound. Sometimes it is too large to pass through the membranous space. In that case, the incision should be prolonged upwards by separating from each other the two lateral parts of the thyroid cartilage. As soon as the foreign body is removed, and the patient's breathing restored, the wound may be drawn together by adhesive straps, and permitted to heal.

Tracheotomy is now seldom resorted to, both on account of the difficulty of the operation, and the danger of wounding important blood vessels. Should it ever become necessary, however, it may be done in the following way. The surgeon makes an incision, from below the cricoid cartilage, and extends it through the skin and platysma-myoides, nearly as far as the sternum. The sterno-hyoidei and sterno-thyroidei muscles are next carefully pushed aside by the fingers, until the surface of the trachea is cleared, and when all hemorrhage has ceased, two or three of the rings of the trachea may be divided by a perpendicular cut.

These operations may be required for other purposes than the removal of extraneous bodies, and in that case the surgeon will generally find it necessary to keep the orifice of the wound open for some time afterwards. This should not be done, I conceive, by a cannula, which, independently of its liability to become clogged by the mucus of the passage, excites always a great deal of irritation. Upon two or three occasions in which I have found it necessary to open the membranous space, in order to sustain the patient's breathing, I have dissected away the corners of the crico-thyroid membrane, and instead of intro-

ducing a cannula into the larynx, have merely prevented the integuments and muscles surrounding the opening from closing, by passing a piece of tape around the patient's neck, having attached to each of its extremities a piece of silver wire doubled, and bent in the form of a hook, and calculated, by pulling these parts in opposite directions, to keep them asunder—at the same time covering with a bit of gauze the opening in the larynx, to prevent the admission of dust and other extraneous matters. Laryngotomy and tracheotomy will sometimes be necessary, on account of substances lodged in the *œsophagus*, for *cynanche trachealis* or croup, for enlargement of the tongue or of the tonsils, for ulceration of the glottis, for suspended animation in persons apparently drowned, &c. In cases of croup, the operation seldom succeeds, owing to effusion having generally taken place in the lungs before the expedient has been resorted to. Some surgeons, and particularly Desault, in place of opening the larynx or trachea, on account of obstructions in the *œsophagus*, introduce a gum elastic tube into the windpipe, from the nose or mouth, with a view of sustaining respiration until the obstructions are removed. The practice, putting the difficulty of the operation aside, in my estimation, is injudicious and censurable.



SECTION IV.

Ulceration of the Glottis.

FROM syphilis, abuse of mercury, and from other causes, the glottis is sometimes ulcerated, the epiglottis destroyed, the bony portion of the thyroid cartilage rendered carious, and covered with abscesses. This disease originates in the glandular structure of the larynx and trachea, and increases gradually, if not arrested, until it destroys the patient. The symptoms are a troublesome, hacking cough, with purulent and bloody expectoration, great difficulty of breathing, a peculiar, husky, wheezing, whistling, almost inaudible voice. After labouring under the disease for a few months, the patient dies from suffocation, from effusion upon the lungs, or from irritation. Sometimes the disease appears to be hereditary; at least, I have upon several occasions known different members of the same family attacked in succession by it. Some years ago, I attended with Dr. Shaw, of this city, a female, who laboured under the disease, and finally died from it. Her sister, a stout healthy young woman, was attacked a few months afterwards in a similar manner, and also died.

Treatment of Ulceration of the Glottis.

When there is reason to suspect that ulceration of the glottis or epiglottis depends upon a syphilitic taint, mercury, sarsaparilla, the nitro-muriatic bath, and other remedies of similar cha-

racter should be employed. As a local application, there is nothing so serviceable as a solution of the argentum nitratum in the proportion of forty grains to an ounce of water. The practice originated, I believe, with Sir Charles Bell: his mode of applying the caustic is to attach a pad of lint to a piece of wire, dip it in the solution, and, taking care to depress the tongue with a finger, place the lint in contact with the ulcerated surface. As a measure of necessity, Mr. Bell once performed the operation of laryngotomy, for ulceration of the glottis, with instantaneous relief to the patient, who continued to breathe freely through the opening for six weeks, but at last died in consequence of closure of the aperture by fungous granulations, the growth of which it was found impossible to repress.

SECTION V.

Bronchocele, or Goitre.

THE terms *Bronchocele*, *tumidum Guttur*, *Hernia bronchialis*, *Gongrona*, *Hernia gutturis*, and others of similar import, are employed to denote a morbid enlargement of the thyroid gland. The word *Goter* or *Goitre*, was invented by the Swiss, and is probably a corruption of the Latin phrase *Guttur*. In England the disease is known in popular language, under the name of *Derbyshire neck*, or *monstrous craw*.

Bronchocele has prevailed, in certain countries, from time immemorial. It is noticed by some of the ancient poets, and by many of the early writers on medicine. It is met with oftener in mountainous than level countries, and is frequently endemial and hereditary. According to Coxe, the disease is common in the neighbourhood of Berne, Friburg, Lucerne, Aigle, Bex, Dresden, in the valleys of Piedmont and Savoy, in most parts of the Vallais, in the Valteline, &c.* In the village of La Batia, Dr. Reeve saw many cretins and goiterous persons, who all lived in adjoining houses.† The village of Villeneuve d'Aoste, which is surrounded by very high mountains, contains an immense number of persons who labour under goitres of enormous magnitude.‡ The late Dr. Howard of Baltimore, during his rambles in Switzerland, first met with goiterous persons and cretins near Sion. The number of each continued to increase as he approached Martigny and St. Maurice, at which places they were exceedingly numerous. As he descended the Rhone

* Coxe's Travels in Switzerland.

† Reeve's account of Cretinism, in the *Edinburgh Medical and Surgical Journal*, vol. 5, p. 33.

‡ Saussure's *Voyages dans Les Alpes*.

their numbers decreased. In the year 1800, the villages of St. Jean, St. Michel, St. Maurice, and the vicinity of Aiguebelle, according to Foderé, contained a greater proportion of cretins and persons labouring under goitre than any other part of Switzerland. Dr. Howard was informed that both cretinism and goitre had diminished within the last few years, in consequence of the richer inhabitants sending their children, until their tenth or twelfth year, to the mountains, where their wives also remained during pregnancy, and for some time after parturition. In the mountainous parts of Spain and Germany goitre prevails to a considerable extent. In France it is chiefly met with in the districts of Cevennes, Soissonais, Vosges, Rouergue, Doubs, and Ardeches. In England it is very common in the mountainous parts of Derbyshire, in Buckinghamshire, Surry, and in the county of Norfolk. Occasionally it is seen in Nottinghamshire.* Sir George Staunton says, that goitres are very common in those parts of Chinese Tartary which resemble the mountains and valleys of Savoy and Switzerland.† “In Bengal,” says Turner, “this unsightly tumour is known by the name of gheig and aubi; and in Boutan is called bà or ke ba, the neck swelling, and forms itself immediately below the chin, extending from ear to ear, and sometimes growing to such an enormous size, as to hang from the throat down upon the breast. It is particularly observable among the inhabitants of the hills of Boutan, immediately bordering upon Bengal, and in the tract of low country watered by the rivers that flow from thence to the south, beyond the space of a degree of latitude. The same malady prevails among the people inhabiting the Morung, Nipal, and Almora hills, which, joined to those of Boutan, run in continuation, and bound, to the northward, that extensive tract of low land embraced by the Ganges and the Burrampooter. The same disease is also more particularly met with in the low lands adjoining those hills. From the frontier of Assam, north latitude twenty-seven degrees, east longitude ninety-one degrees, it is to be traced through Bishee, Gooch, Bahar, Rungpore, Dinagepore, Purnea, Tirrooto, and Betiah, along the northern boundary

* Clark's Reports from the general Hospital near Nottingham, in the *Edinburgh Journal*, vol. 4.

† Staunton's *Embassy to China*.

of Oude, in Gooracpore, Barraitch, Pillibeat, and on the confines of Rohilcund to Hurdwar, situated in north latitude thirty degrees, east longitude seventy-eight degrees twenty-five minutes. It has the effect, or is rather accompanied with the effect arising from the same cause, of debilitating both the bodies and the minds of those who are affected with it.”* Park, in giving an account of the diseases of the Mandingo negroes, states that goitres are very common in some parts of Bambarra.† Throughout the island of Sumatra, bronchocele is met with as an endemic disease, and is particularly frequent in those valleys which are surrounded by the highest mountains.‡ In some of the Spanish settlements of America, goitres are so common, that the greater number of the inhabitants labour under the disease; and at the village of Jacaltenango, near Sacapula, it is said that no individual can be found without an enlargement of the thyroid gland.§ In Santa Fee, Guatemala, Nueva Gallicia, and Nicaragua, the complaint has long been known. It is common also among the Indians who inhabit the valleys of the Cordilleres. According to Humboldt and Bonpland, goitre is an endemic disease at New Grenada, and is so common at the small villages Hunda and Monpar, on the borders of the Magdelaine river, that it is difficult to find an individual who is exempt from it. It affects indiscriminately all classes of inhabitants, except the blacks and those who lead a very laborious life. The ferrymen at Carthagena are not subject to it. Females are oftener affected than males. At the Isthmus of Darien many persons are horribly disfigured by enormous bronchoceles.|| In various districts, and throughout whole tracts of country in North America, bronchocele prevails as an endemic. It is very frequent in many parts of Lower Canada, especially near the marshes between St. John’s and Montreal. At Detroit, Lake Ontario, Oneida, Erie, Huron, and among the Tuscorora, Seneca, Oneida, and Brothertown Indians, it is very common.¶ In many parts of the state of Vermont, especially Bennington and Chittenden, bronchocele is well known. It is also found at

* Turner’s Account of an Embassy to Tibet.

† Park’s Travels in Africa.

‡ Marsden’s History of Sumatra.

§ Barton’s Memoir on Goitre.

|| Alibert’s *Nosologie Naturelle*, p. 470.

¶ Barton’s Memoir.

Camden, Sandgate, and Chester, in the same state. Sandgate, some years ago, contained one thousand and twenty inhabitants, and out of that number one-fourth of the females were affected with the disease.* According to Dr. Trask, bronchocele is so common a disorder at Windsor in Vermont, that hardly any female is exempt from it.† In the state of New York goitre prevails principally in the neighbourhood of Old Fort Schuyler, the Oneida village, the German Flats, Fort Herkimer, Fort Dayton, Henderson town, Onondago valley, Canasara, Brothertown, the townships of Manlius, and the whole of the military district.‡ I am informed by Philip Church, Esq., who resides at Angelica in Alleghany county, state of New York, that goitre is a very frequent complaint in his neighbourhood and the surrounding country. In Pennsylvania, where bronchocele is very common, it is found chiefly at Pittsburgh, on the waters of the Alleghany, Sandusky, Monongahela, French Creek, at Canonsburgh, Brownsville, and throughout the county of Somerset. In some parts of Virginia, especially at Morgantown and on the banks of Cheat river, it is by no means unfrequent. In certain situations on the western shore of Maryland, and in North and South Carolinas, the disease is occasionally met with.§

* Dorr's Facts concerning Goitre, New York Medical Repository, vol. 10.

† Mease's Observations on Goitre.

‡ Barton.

Dec. 22d, 1831.

§ DR. GIBSON,

SIR, I take the liberty of communicating to you a fact, which has fallen under my observation, relative to the disease known by the name of goitre, or bronchocele, which, if it be not useful in throwing some light on the cause of this inexplicable affection, will at least prove curious to the surgeon and physician.

At King's Saltworks, in the county of Washington, Virginia, and not far from my own residence, this disease has prevailed for a number of years; for any thing that I know to the contrary, its existence is coeval with the commencement of the manufacture of salt at that place. Hitherto, it has been confined exclusively to females, and to those who reside at the very spot where the process of vaporization is carried on; the subjects of it consisting chiefly of the families of the immediate superintendents. Persons living at the distance of a half, or even quarter of a mile are not subject to the disease.

Contrary to what might be supposed from the aspect of the neighbouring country, this disagreeable affection is of exceedingly rare occurrence in this part of the state, with the exception above alluded to. No satisfactory reason has been assigned for its existence at this place. It has, however, been ascribed to the water used

It is probable, indeed, that goitre may be found as an endemic disease, in almost all the mountainous and marshy districts throughout the United States. All writers on the complaint, agree that it generally prevails in valleys at the bottom of the highest mountains, which are particularly exposed to the influence of easterly and southerly winds. In those situations, moreover, where the temperature is mild and uniform—where the atmosphere is moist—in the neighbourhood of rivers, of falls or lakes, or of the sea,—where the soil is rich and the habitations surrounded by fruit trees, goitres are commonly found.

Every age and sex is liable to goitre, but females are oftener affected than males. In children, it seldom occurs until after the eighth or tenth year, and old people are little subject to it. Three instances, however, are mentioned by Foderé, where it was found at birth, and another, in an infant fifty days after birth.* Dr. Sterndale has also furnished an example, where a child in Derbyshire, was born with a goitrous tumour of considerable size.† Those females who are not subject to bronchocele before marriage, generally perceive its commencement during pregnancy.‡ Persons of relaxed constitutions, of white and delicate skins, and whose complexions are red mixed with a brownish tinge, are most predisposed to the disease. Children who are to become goitrous, have large blue, sprightly eyes, beautiful skins, and fair hair. Their memory is very forward. When the disease appears, every thing is changed. As it advances, the eyes become dull, the face acquires a white colour and unmeaning look, and the faculties are at a stand. When the goitre is very large, respiration becomes difficult, the pronunciation of consonants

for drinking. I have drunk of the same water myself, and found it insipid and unpalatable; but was unable to detect in it the presence of any other mineral but lime, which is the common character of the water of the country. It may, perhaps, be proper to state, that a removal to another situation is not attended with a removal of the complaint.

Whatever may be the cause of this disease, as it exists here, which, I think, is entirely inscrutable, such is the certainty with which it attacks those who come within the sphere of its influence, that every woman who goes to King's Salt-works to live, previously makes up her mind to become sooner or later a subject of goitre.

JOHN T. SMITH, M. D.

* *Traité du Goitre et du Cretinisme.*

† *London Medical Repository*, vol. x. p. 200.

‡ *Foderé*, p. 62.

imperfect, and the body ceases to increase except about the head and shoulders. In a goitrous country, the children are born goitrous after two generations of the intermarriage of goitrous parents. After the third marriage, the child becomes a cretin. A semi-cretin, weak and ricketty, married to a goitrous woman, has children born goitrous.* During the winter, a goitrous tumour is diminished in size, but it augments with the return of warm weather, and is larger during autumn than at any other season. The disease is not confined to the human race; horses, horned cattle, calves, sheep, dogs and other inferior animals are subject to it.†

In the commencement of bronchocele, a small tumour may be perceived, either on one or both sides of the trachea and larynx. Sometimes the swelling occupies each lobe of the thyroid gland, together with its isthmus, so as to constitute a uniform tumour; at other times, there is a depression at the centre, following the course of the trachea, and marking the natural division of the lobes. Occasionally the enlarged lobes are studded over with a number of lobules. The swelling generally continues small and circumscribed for a considerable time, and often extends backwards, so as to render it difficult to ascertain by inspection or examination, whether goitre exists or not. For the most part, it is soft to the touch, and possessed of so little sensibility, that it may be rudely handled, without producing much uneasiness. It is sometimes closely compressed by the muscles which cover it, and is then elastic and firm. Although the thyroid gland, both in its natural and enlarged condition, is not very susceptible of inflammation, yet, when this state is once induced, it becomes exquisitely tender, and is accompanied with a difficulty of respiration and deglutition, which the most active antiphlogistic measures can hardly subdue. Almost all the goitres which have come under my notice in America, have commenced in one lobe of the gland—the other lobe in a short time being affected in a similar manner. Alibert says that he has found the right lobe oftener enlarged than the left.‡ In the worst cases of goitre I have seen, the tumour has exceeded in size a large cocoa nut, and has become at particular times very

* Foderé, also Chapman's Notes on Allan's Lectures.

† Cox's Travels, Barton's Memoir, Clark's Reports.

‡ Nosologie Naturelle.

troublesome to the patient, by its weight and pressure upon the trachea and adjacent parts. In countries where the disease is endemic, it is not uncommon for the tumour to attain an enormous magnitude. Foderé relates instances of such tumours weighing seven or eight pounds.* A case is recorded by Alibert, of a man thirty-eight years of age, who had a goitre which extended below the middle of the chest and equalled in size a large pumpkin. “La poche énorme qui s’est formée au dessous de son menton, ressemble à celle de l’oiseau désigné communément sous le nom de *pelican*, et qui figure comme objet de curiosité dans les cabinets des naturalistes.”† The same author details the case of a female, upwards of sixty years old, who had resided the greater part of her life near Chamouny at the foot of Mont Blanc, and who, from her infancy, had laboured under a bronchocele, which was divided into innumerable lobes, which extended from ear to ear, blocked up the cavities of each, so as to destroy the hearing, and finally descended on the chest, lower than the mammæ, interrupting the breathing and swallowing to such a degree, as almost to produce suffocation, every time she attempted to take the least particle of nourishment, solid or fluid. But cases have been related by Mittlemayer and others, in which goitrous tumours have descended below the umbilicus, and even to the knees.‡ We have no reason to suspect these accounts exaggerated, when we remember the reports of Sir Robert Wilson, Larrey and others, respecting those prodigious tumours, common in Egypt and many warm climates, in consequence of the descent of the abdominal viscera, which, in some instances, have reached the ground. The cases of enormous hydroceles, also, recorded by Keate, and the voluminous cutaneous excrescences described by Mr. John Bell and by Dr. Roper of Charleston, leave no doubt on the subject.

Notwithstanding the peculiarities of goitre, it is not easy always to distinguish it from other diseases. It may be confounded with aneurism of the carotid artery, with scrofulous enlargement of the lymphatic glands, with encysted and sarcomatous tumours of the trachea and its vicinity, with dilatation of the internal jugular vein, and perhaps with other complaints. From aneurism it may be distinguished, in general, by want of

* *Traité du Goitre, &c.*, p. 467.

† *Nosologie Naturelle*, p. 468.

‡ *Dissertatio de Strumis et Schrophulosis* 1723.

pulsation, by the comparative insensibility of the tumour, by the softness of its texture, by its mobility, and by the circumstance of the swelling accompanying the motions of the larynx and trachea, when the patient is desired to imitate the action of swallowing. But sometimes the goitre is so large, and is so identified with the adjacent cellular texture, that little or no movement of the trachea can be observed. When goitre is extensive, and occupies one side of the neck only, and when, at the same time, there is a pulsation in it from the enlarged and varicose state of the vessels, we shall not find it always easy to discriminate between it and aneurism. Occasionally a pulsation is communicated from the carotid to a goitrous tumour, which happens to lay over it. One instance is noticed by Burns, where the carotid was deeply imbedded in the substance of an enlarged thyroid gland. "The carotid artery being placed," says he, "in the body of the tumour, is neither very rare in occurrence, nor very difficult to explain. It is, indeed, a natural consequence of the extension of the tumour laterally; yet it will not happen in every tumour: it will only occur in those cases, where the consistence of the morbid parts is soft. When the tumour is firm, it pushes the artery, nervus vagus, and internal jugular vein aside. When it is soft, these, as in the present instance, sink into its substance."* In most instances of aneurism, however, the carotid is deeper seated than bronchocele, and the pulsation so strong as scarcely to be mistaken. Notwithstanding this, cases have been related where the most able surgeons have found it impossible to offer a decided opinion. A creole negro had a tumour on the neck, which was submitted to the inspection of some of the most celebrated surgeons in America, Paris, and London; all of whom pronounced the disease an aneurism of the carotid artery; but it was afterwards ascertained, by Boyer, that no such disease existed—but simply an extensive enlargement of the lymphatic and other glands of the neck.† The late Dr. Samuel P. Griffiths has furnished us with an interesting history of a tumour of the neck, bearing so strong a resemblance to carotid aneurism, as to be mistaken for the disease by himself, Drs. Chapman and

* *Surgical Anatomy of the Head and Neck*, page 224.

† *Dictionnaire des Sciences Medicales*, vol. xviii. p. 541.

Morgan, and the late Dr. Dorsey. Upon dissection by Dr. Parrish, it was distinctly ascertained that the carotid was free from disease, and that the tumour was composed entirely of the thyroid gland.

"It was elongated," says Dr. Parrish, "and had obtained a situation directly over the carotid artery; the patient's neck was very short, the pulsation in the carotid was imparted to the tumour lying over it; and, I am informed, there was a strong resemblance to the aneurismal jar or thrill. We are aware, that in dropsy of the chest and pericardium, the heart often palpitates most violently; and this morbid pulsation may explain the throbbing of the carotid, which bore so strong a resemblance to aneurism."* One circumstance which deceived Dr. Griffiths, was the impossibility of drawing the tumour from the artery. "I had frequently endeavoured," says he, "to remove, with my fingers, the tumour from the artery, wishing to think the disease was glandular, but could not succeed, as the tumour was so firmly fixed over the vessel as not to be moved from it; and the pulsation was such as to convey the idea that there was no intervening substance." Under ordinary circumstances, this plan of drawing the tumour from the artery is excellent. It was by relaxing the muscles of the neck, and separating with the fingers the tumour from the artery, that Boyer was enabled, in the case referred to, to discriminate between the disease and aneurism. By similar means, I have often succeeded in distinguished enlarged glands and other tumours situated over large arteries, in different parts of the body.

Many writers have confounded goitre with scrofula: but there would appear to be no legitimate foundation for such a conclusion. In scrofula, the lymphatic glands of the neck and other parts of the body are particularly involved; and other marks in the system, too well known to require description, evince the existence of the scrofulous constitution. These symptoms do not generally accompany the goiterous tumour. Goitre is strictly a local complaint—scrofula affects the whole system, and appears at a much earlier period of life than goitre. In countries where bronchocele is endemic, the scrofulous are equally liable, no doubt, with others, to the complaint. Persons

* Eclectic Repertory, vol. ix. p. 120.

who remove from settlements where goitre does not exist, into countries where the disease prevails, are subject to it; but on residing again for some time at their original home, the tumour disappears generally in a short time. This is seldom the case with scrofula, which is little influenced by change of climate. The scrofulous tumour is harder to the touch, and more painful than the goitrous tumour. It is more disposed to suppurate than bronchocele; besides, goitre is nearly unknown in certain countries, where scrofula is the common disease. In Scotland, scrofula is almost universal,—goitre hardly ever met with. In Switzerland, goitres are very common, and affect all classes of society, while scrofula is very rare. It is possible for an enlarged thyroid gland to extend so far beyond its natural boundaries, as to occupy the situation of the lymphatic glands of the neck. Mr. Burns has furnished a very instructive case of this kind, in which it would have been impossible, perhaps, without dissection, to have ascertained the true nature of the swelling. “Beneath the sterno-mastoid muscle,” says he, “the enlarged gland was lobulated and clustered into small processes, precisely resembling a chain of enlarged concatenated glands. Indeed, had I alone trusted to the impressions received before dissection, I would have been led to believe that the lymphatic glands of the neck were actually swelled, and, besides that, several of the conglobate glands, placed behind the sterno-mastoid muscle, between it and the trapezius, were also affected; for into that space processes from the left lobe of the thyroid gland extended.”*

A dilatation of the internal jugular vein is not an uncommon disease, and may sometimes be mistaken for goitre. It may be distinguished, generally, by its low situation—the swelling appearing just above the sternum. The tumour may also be known from goitre, by its softness and compressibility, by its pulsatory and tremulous motion—by the sudden return of the tumour, when pressure is removed—by more or less turgescence, along the whole course of the vein. I once attended a patient, four or five years of age, with Dr. Jennings of Baltimore, upon account of a large swelling of the neck, the precise nature of which, it was difficult to ascertain for some time. It resembled in many respects the enlarged thyroid, and in others, diseased lymphatic

* Surgical Anatomy, p. 196.

glands, but turned out to be a dilatation of the internal jugular. The interesting case of a tumour of the neck, detailed by Mr. Hey, the nature of which he could not ascertain, I have no doubt, was an enlarged vein, and probably the jugular.* The morbid distention of this vessel has been confounded occasionally, with aneurism of the aorta.†

An encysted tumour may occupy the anterior surface of the trachea; in many respects it is analogous to goitre—is free from pain—is soft and doughy to the feel—follows the motions of the larynx and trachea, and may attain a considerable size. It extends on the trachea as high as the thyroid gland, and descends behind the sternum. The disease has never been described, I believe, as occupying this situation. I have seen only two or three cases of it. An officer of the army consulted me, some years ago, respecting such a tumour, which had been shown, previously, to several practitioners, who could not give a decided opinion as to its nature. At first I suspected it to be a goitre, but the patient assured me that it had emerged, originally, from behind the sternum, and was occasioned, so far as he could determine, by the pressure of a leather stock, which had been worn unusually tight. This circumstance inclined me to believe, that the tumour had no connexion with the thyroid gland, and determined me to puncture it with a lancet. A thick, yellow, cheesy matter, extremely offensive, and three or four ounces in quantity, was discharged from the wound by pressure. The opening was then enlarged, and a probe could be passed to a considerable distance behind the sternum, and upwards along the trachea. The cavity was filled with lint and stimulating injections were frequently employed. Suppuration was established with difficulty, and the cavity was filled up in the course of two or three months. I met with a similar disease afterwards, in a young woman seventeen years of age, and removed it by the same treatment. The wound, however, remained fistulous for a considerable time, in spite of every remedy used. In both cases, these tumours extended so far upwards, and were so deeply imbedded under the sternum, that any attempt at excision would have been hazardous, if not impracticable.

In its natural state, the thyroid gland is found to vary in dif-

* Hey's Practical Observations in Surgery, third edition, p. 448.

† Burns on the Diseases of the Heart, p. 259.

ferent subjects. In females, it is larger than in males. It is generally made up of distinct lobules, which are collected into numerous lobes or tuberculated masses, joined to each other by a very fine cellular membrane. Rounded vesicles, containing a colourless, but sometimes yellowish fluid, are mixed with the lobes. In many subjects these vesicles cannot be discovered, and the existence of a fluid is ascertained, only by rubbing slices of the gland between the fingers, when a peculiar feeling of viscosity may be observed.* There is no proper investing membrane or capsule to the thyroid gland; but the cellular texture is slightly condensed on the surface, so as to furnish a very thin covering, from which processes proceed internally, and form septa or partitions in various directions. The substance of the gland generally consists of two portions, which are placed on each side of the trachea and larynx, and united to each other by a transverse band or slip of the same substance. Sometimes this band is wanting, and then there are two distinct thyroid glands.† No unquestionable excretory duct has yet been discovered. But small openings or canaliculi, described by Morgagni, Bordeu, Walter, and some other anatomists, have been found on the internal surface of the trachea. These openings uniformly occupy one situation, and are two or three in number. They may be found about the middle of the internal surface of the *first* cartilaginous ring of the trachea. Bordeu, in speaking of this ring, says, “Nous avons aussi remarqué, qu’il est, dans tous les sujets ou divisé par une fente plus ou moins étendue et située vers le devant du cartilage, on perce d’un ou deux, et même de trois trous bien apparens et placés aussi, vers le milieu du cerceau sur le devant, ou un peu à côté.

“Ces trous nous frappèrent la première fois que nous les vîmes: c’étoit à Montpellier, en 1741, en disséquant un larynx auprès du feu; la glande thyroïde qui étoit extrêmement grosse, étant enlevée, nous trouvâmes le premier cerceau presque osseux, mais assez transparent pour laisser apercevoir, au moyen du feu, les deux trous qui n’étoient recouverts que par des membranes lâches qu’ on emporta facilement.

“Après bien des recherches, on trouva un sujet mort de morte violente; nous examinâmes d’abord la face postérieure

* Anatomie Descriptive, par X. Bichat.

† Soemmering de corp. hum. fabric. vol. 6, p. 39.

du cerceau de la trachée, sans avoir touché la thyroïde; la membrane interne de ce cerceau étoit pleine de petits trous difficiles à apercevoir; nous introduisimes des soies dans cinq de ces trous, et en les conduisant légèrement, elles allèrent se rassembler en deux endroits, trois dans l'un et deux dans l'autre; ces endroits étoient précisément les deux trous du cartilage; ces soies allèrent, en les pousant, se perdre dans la glande. M. Barbuot, medecin de Semur, étoit présent à cette opération."*

From a perusal of these and other passages in Bordeu, some years ago, I was induced to examine the openings described, in a great many subjects, under an impression that they were the mouths of excretory ducts from the thyroid gland. To ascertain this, I made a number of experiments with the mercurial injecting apparatus, the small pipes of which were introduced directly into the openings in the cartilage, and found that the mercury sometimes passed with facility through these small canals, but met with resistance when it reached the thyroid gland. In three or four instances I succeeded in pushing it to a considerable distance under the cellular covering of the gland, and even among the cellular texture into the substance of the gland, as I afterwards ascertained by cutting it open. But, in all probability, the mercury passed, in each case, from rupture of the cellular tissue, and did not follow the natural course of the duct. I endeavoured to find a communication between the thyroid gland and the ventricles of Galen, and with this view introduced the mercury into the bottom of each of these cavities. After several ineffectual attempts, I succeeded in filling the cellular texture of the thyroid, and to a much greater degree than from the openings of the trachea. I mention these circumstances to corroborate the suggestions of Morgagni and Bordeu, that there are passages from the thyroid gland, which serve to deposite its secretions in the trachea, and perhaps in other places. The observation may be useful to those who feel disposed to investigate the subject further. In addition, I may state, that Foderé succeeded in blowing air from the larynx into the thyroid gland, so as to distend it considerably. In another instance he filled the trachea with spirit of wine, and upon cutting into the thyroid gland, the smell of the liquor was distinctly perceivable.

* Œuvres complètes de Bordeu, par Richerand, tom. 1, p. 98.

“Qu’on prenne,” says he, “un larynx auquel, cette glande est attachée, bien lavé et nétoyé avec une légeré dissolution de potasse, et ensuite séché, qu’on en bouche exactement l’extremité inferieure, puis qu’on adapte au trou de la glotte, un tube contigue à une vessie pleine d’air, et qu’on lutte bien l’appariel; en comprimant la vessie, on verra la glande thyroide augmenter de volume.

“La même expérience réussit, quoi qu’à un moindre degré, avec l’alcool. En coupant la glande après avoir comprimé, la vessie, on sent distinctment l’odeur de ce fluide.”*

Lalouette discovered an immediate connexion between the thyroid gland and the lymphatic vessels which pass along the thyroid and cricoid cartilages.† Many cases have been recorded by different writers, where an enlargement of the thyroid gland has been suddenly produced in consequence of violent exertions of the muscles of the neck in lifting heavy weights, or in consequence of laborious efforts of the patient during protracted and difficult parturition. It has been maintained, also, that goitre is produced among the inhabitants of certain European districts, from the habit, which is frequent among the lower order of people, of dragging burdens up the hills by cords tied round the upper part of the chest. According to Mr. Heckewelder, who often met with goitre among the American Indians, the disease never made its appearance among the girls until they began to carry heavy burdens on their heads.‡ These circumstances would favour the idea of Bordeu, Foderé, Morgagni, and others, of the existence of a direct communication between the trachea and thyroid gland.§ Many theoretical uses have been assigned to the thyroid gland, besides those already mentioned. It does not come, however, within the scope of my purpose to detail them.||

When a goitrous tumour is examined by dissection, several circumstances are presented worthy of notice. One or both lobes, and sometimes the middle lobe or isthmus of the gland, are found enlarged beyond their natural boundaries. Upon cutting

* *Traité du Goitre et du Cretinisme*, p. 58.

† *Haller Elementa Physiologiæ*.

‡ *Barton’s Memoir*, p. 46.

§ See *Morgagni’s Adversaria*, 5, p. 66.

|| Those who wish for information on the subject may consult *Haller’s Elementa Physiologiæ*, lib. 9, p. 22. *Soemmering de corp. hum. fabr.* vol. 6, p. 41. *Coxe’s Museum*, vol. 3, p. 27.

into their substance, the texture is found more or less compact, intermixed with numerous cells, containing a transparent glutinous liquor, which may be drained off in such quantity, by pressure, as to reduce considerably the bulk of the tumour. These cells vary in size; some being large enough to contain a pea, while others are exceedingly small. The fluid they contain becomes a solid transparent jelly, when the gland has been immersed for some time in proof spirits.* Although the thyroid gland in its natural state is abundantly supplied with large arteries, yet its capillary vessels are comparatively few, and the quantity of blood determined to its substance not so great as commonly supposed. In bronchocele all the vessels are greatly enlarged, and varicose, and the quantity of blood materially increased, as is evinced by the throbbing of the tumour during life, and by injection of it after death. This preternatural accumulation of blood so frequently accompanies the kind of diseased enlargement of the gland which I have described, as to cause some writers to rank it as a particular species of goitre,—denominated *sanguineous goitre*. This distinction, as well every other division of the disease into species, is perhaps improper, inasmuch as the appearances presented on dissection are never sufficiently uniform to enable us to characterize with precision each morbid change of structure. It is certain, however, that an unusual determination of blood generally accompanies the structure I have described,—and which nosologists have called the *sarcomatous bronchocele*. In all probability, the other species mentioned are but varieties of this common and perhaps original form of the complaint.

Sometimes the texture of the goitrous tumour, instead of being compact and solid, is soft and spongy, and large cavities or membranous vesicles are dispersed throughout, which contain a thin, limpid, or serous fluid. This has been called the *encysted, serous, or watery bronchocele*. It is a modification only of the common disease; for sometimes the fluid changes into a yellow tenacious, and melicerous matter. The cells of the thyroid gland are said to have been filled, occasionally, with hydatids; but such appearances may have been confounded with the watery collections just described. The *bronchocele ventosa* cannot be considered as a variety of goitre, but only an emphy-

* Baillie's Morbid Anatomy, p. 86. Also, Engravings, Fasciculus, 2, p. 25.

sematous tumour of the gland, or of the adjacent cellular texture.

It is not uncommon to find in the substance of goitres, of long standing, bony particles, and even considerable masses of ossified matter. Several examples of the kind are mentioned by Bonetus, Morgagni, Kerkringius and other old writers. Dr. Baillie, in his *Morbid Anatomy*, speaks of the thyroid gland being sometimes converted, in old people, into a bony mass. In this respect the disease nearly resembles other sarcomatous tumours, in which we are accustomed to meet with cartilaginous and ossified productions. Calcareous concretions are said to have been discovered, in the substance of the thyroid gland, affected with goitre.* Pieces of tuft stone have been removed from the thyroid gland, in several instances, by a Swiss surgeon.†

The substance of bronchocele is seldom converted into purulent matter. But cases have been recorded by Petit and Hevin, where spontaneous cures were effected in this way. Severinus relates a case in which purulent matter was discharged from a bronchocele mixed with a substance resembling charcoal.‡ Dr. Baillie has given a drawing of a preparation contained in the Hunterian cabinet, where an abscess formed in the right side of the thyroid gland and afterwards communicated by ulceration with the trachea, so as to suffocate the patient.§ Alibert relates the case of a patient in the hospital of St. Louis, who laboured for years under an enormous bronchocele, and was eventually relieved of his burden by suppuration taking place in its substance. Ulceration was spontaneously established, and upwards of five pounds of purulent matter discharged.||

Burns gives an instance, where suppuration took place in both lobes of the thyroid gland. The matter was slowly secreted and the integuments became gradually distended, until they formed a large pouch which hung over the sternum, and contained several pounds of pus. The sides of the cyst united, and the patient was ultimately cured.¶ In speaking of abscess,

* Haller's *Elementa Physiologiæ*, Vol. III. p. 400.

† Coxe's *Travels*.

‡ *De Recondita Abscessum Natura*, p. 194.

§ *Series of Engravings*, p. 27.

|| *Nosologie Naturelle*, p. 467.

¶ *Surgical Anatomy*, p. 188.

following bronchocele, Portal remarks, that the cartilages of the larynx and rings of the trachea, are sometimes eroded by caries. "On a trouvé dans des sujets qui étaient morts de suffocation, les cartilages thyroïde, cricoïde, et les anneaux cartilagineux de la trachée artère, rougés par la carie, à la suite d'un abcès dans la thyroïde. Valsalva, Morgagni, Lieutaud ont cité de pareils exemples dans leurs ouvrages."*

I have had three opportunities of dissecting goitrous tumours. The first was in a man upwards of sixty years of age, who had laboured under a very large and turberculated swelling of the thyroid, almost from infancy. The tumour occupied both sides of the trachea, and was very solid, and insensible to the touch. It produced very little inconvenience, and the patient died of another complaint. Upon dissection, I found each of the enlarged lobes completely sarcomatous, without any membranous vesicles, or fluid, except a thick yellowish, lardaceous or oleaginous matter, in small quantity, which could be pressed, by force, from the diseased mass. Fibrous bands, similar to those which occur in the scirrhus breast or testicle, intersected the tumour in various directions. The larynx and trachea were not altered in structure, but the mouths of the small muciparous ducts, which open on the lining membrane of the trachea, were not perceptible; and the *tracheo-thyroidal* passages of Bordeu appeared less conspicuous than usual.

Some years ago I had an opportunity of inspecting the body of a woman thirty-five years of age, who died of apoplexy. A large tumour occupied the left side of the thyroid gland. Upon turning aside the sterno-thyroides and omo-hyoïdes muscles the gland was brought into view, and presented an immense number of varicose veins distributed over its surface; all the parts in the neighbourhood, seemed vascular in the extreme. Upon opening the gland a considerable quantity of thin greenish fluid was discharged, and the small cells which contained it were distinctly perceived. The right side of the gland, together with the isthmus, was slightly enlarged; but in other respects appeared to possess its natural structure. This woman, as her husband informed me, had suffered occasionally from inordinate pulsation in the tumour, and from its pressure on the tra-

* Cours d'Anatomie Médicale, tome iv. p. 564.

chea, but in general, experienced little inconvenience. She was a native of Holland, where the disease commenced about the tenth year of her age, and had slowly increased. It appeared to have had no connexion with the complaint of which she died.

With the history of the third subject, I am unacquainted. It was a girl about fourteen years old, who was much emaciated, and had laboured, apparently, for a considerable time, under constitutional disease. Both sides of the thyroid were involved; but the disease was evidently in its commencement. The vessels of the gland were slightly varicose, and the cellular structure of the interior contained a small quantity of transparent fluid. The larynx and trachea were unaltered, and the small openings of the first cartilaginous ring were distinctly observable.

The causes of goitre are involved in much obscurity. This will account for the numerous, diversified and contradictory speculations on the subject. By many, the disease has been attributed to the use of particular alimentary substances, especially poor and unwholesome diet;—to the drinking of cold or snow water, or water strongly impregnated with limestone, or other calcareous matters; the immoderate use of spirituous and vinous liquors, debauchery, the repulsion of cutaneous diseases, and many similar explanations have likewise been resorted to; all of which are too hypothetical, and so frequently contradicted by facts, as to deserve no attention. It is certain, that goitre prevails as an endemic disease chiefly in countries where the atmosphere is loaded with moisture, in valleys enclosed by lofty mountains, and which are exposed to the direct and reflected heat of a powerful sun. In some of these valleys, the fogs are visible every morning, rise with the sun in a thick body, and seldom disappear entirely, until the afternoon.* It is, however, well ascertained, that those persons who do not reside in or near the valleys where goitre prevails, but live on the sides or tops of the adjacent mountains, do not labour under the disease. Again, it is a fact established beyond all doubt, that the mere removal of a goitrous person from the valley where he acquired his disease, to the top of the contiguous mountain, will diminish

* Marsden's History of Sumatra.

the size of the tumour, and in time, remove it entirely. The same observations, perhaps, to a limited extent, may be applied to cretinism, a disease so often concomitant, but probably independent of goitre. "All the cretins that I saw," says Dr. Reeve, "were in adjoining houses, in the little village called La Batia, situated in a narrow corner of the valley, the houses being built up under ledges of the rocks, and all of them very filthy, very close, very hot and miserable habitations. In villages situated higher up the mountains, no cretins are to be seen, and the mother of one of the children told me of her own accord, without my asking the question, *that her child was quite a different being when he was up the mountain, as she called it, for a few days.*"* Frequent opportunities are offered in this country, of observing the effects produced on goitre, by the removal of individuals afflicted with it into districts where the disease is unknown. Numerous cures, of very large goitres, have been effected in persons, who acquired the complaint at Pittsburg—simply by spending a few months in Philadelphia, or other distant places. These circumstances indicate, beyond doubt, something peculiar in the atmosphere or in the exhalations from valleys or other places where goitre is found. That the disease, at all events, is not owing to poor living or to the drinking of snow water, is sufficiently proved by the circumstance of its not prevailing in certain countries where the inhabitants are accustomed to subsist on a very meagre and scanty diet. Besides,—the rich inhabitants of the Vallais and of the state of New York, are equally subject to the complaint with the poorer people. In Greenland, and Lapland, where the inhabitants use snow water almost entirely, there is no goitre, while in Sumatra, in Bambarra, and in many other warm countries, where snow is never seen, the disease is very common.†

In those parts of the state of New York, New Hampshire and Vermont, particularly along the course of the Connecticut river, where goitre prevails, it is remarkable that the disease is most common in those places which are covered with wood and are uncultivated; but in proportion as the country is settled and the lands cleared, the disease is found to decline, and in many

* Account of Cretinism, Edinburgh Journal, vol. v. p. 33.

† Vide Marsden, Park's Travels, Humboldt and Bonpland, &c.

places is already nearly extinct.* In 1798, bronchocele was so common at Pittsburg, that, out of 1400 inhabitants, not less than 150 had the disease.† Since that period, the complaint has so much declined, in the same place, that it is said very few now labour under it. The change is usually attributed by the citizens of the town, to the general introduction of coal fires. All these circumstances tend to show that bronchocele is produced by a peculiar atmosphere, or by certain morbid exhalations from marshes or other grounds. What the peculiar nature of this exhalation is, we have no more means of ascertaining, than we have of finding out the constituents and mode of action, of marsh miasma, or of the agents which create yellow fever, or any similar disease. The late Professor Barton imagined goitre to arise from the same causes which produce intermittent and bilious fevers.‡ But it has been ascertained that goitre originates in many districts where intermittents are unknown, and intermittents, on the other hand, are frequent where goitre has never been seen. Along the shores of the Delaware and Chesapeake bays, intermittent and bilious fevers universally prevail, and goitre is seldom found. It is possible, however, that the cause of goitre may be allied to that of intermittent, but so modified by particular circumstances, which we shall probably never be able to ascertain, as to produce very different effects. But those who are anxious for information, respecting all the supposed causes of goitre, should consult the work of Foderé, Coxe's Travels, Saussure's Voyages, Gautieri de Tyrolensium Struma, &c.

Whatever may be the remote physical causes of goitre, I am inclined to believe, that the disease arises immediately from an obstruction of the tracheo-thyroideal passages of Bordeu, of the openings, communicating with the sacculus laryngeus and the thyroid gland, of which I formerly had occasion to speak, or of other passages with which we are unacquainted. I am inclined to draw this conclusion from the circumstance of a watery fluid being found to occupy naturally, the cells of the thyroid gland—from this fluid being increased in quantity in almost every goitrous tumour, and from the passages of Bordeu being much

* Mease's Observations.

† Barton's Memoir.

‡ Vide Barton's Memoir—also, Caldwell's Medical and Physical Memoirs, p. 279.

smaller in the first dissection I made of bronchocele, than they are usually met with in subjects without such disease. *This is a mere conjecture.* Neither is it original—but was advanced by one of the older writers on surgery. I mention it, merely to induce those who have frequent opportunities of investigating the structure of bronchocele by dissection, to attend to the appearances of these passages and to endeavour to discover other communications with the gland.

Treatment of Bronchocele.

The remedies proposed for the removal of this disease are countless—the strongest proof of their inefficiency. It will be sufficient to enumerate the principal—burnt sponge, mercury, pumice stone, muriate of barytes, sulphuret of potash, egg-shells, muriate of lime, digitalis, muriate of iron, belladonna, electricity, pressure, friction, issues, setons, blisters, caustic, excision, and ligature of the thyroideal arteries. In the commencement of my practice, I employed the burnt sponge in the form of powder, mixed with honey and other materials,—the lozenges of Ring, which consist of cinnamon, gum Arabic, sirup and burnt sponge mixed—the simple decoction of the sponge, as recommended by Herrensward of Berne, in Switzerland,—but generally without any decided effect.* In two instances, I succeeded in removing small goitres by the use of sulphate of potash, continued for several weeks in large doses. This remedy is said to have effected many cures, in the hands of Foderé and other practitioners. The different preparations of mercury and antimony, muriates of lime and barytes, I have tried without the slightest advantage. In one case, after the inefficacious exhibition of many of the remedies mentioned, the late Dr. Cromwell, of Maryland, effected a complete cure in a patient upwards of twenty years of

* For an account of the use of these remedies, see Foderé, p. 110. Ring, in the 4th, 5th, and 11th volumes of the London Medical and Physical Journal.

age, who had laboured for some time under a goitre,—by the repeated application of blisters. Mr. Benjamin Bell says, that he arrested the progress of a very large bronchocele by the same means. Stimulating frictions with flannels, immersed in camphorated liniments, and other applications of a similar nature, are commended by Underwood. Foderé remarks that he frequently cured small Spanish dogs of goitre by the same means, at Maurice, where these animals are very subject to the complaint.* Frictions with mercurial ointment and various stimulating plasters, have likewise been extolled by different writers. Boyer has employed, for many years, cataplasms, or bags of emollient herbs, applied directly to the tumour, and worn night and day for weeks or months, and often with success. Compression has sometimes been found serviceable by Foderé; and Dr. Physick once succeeded in effecting a complete cure of the disease, in a lady of this city, by keeping up a continued but moderate pressure by means of a bandage for several months. Mr. Holbrook, a surgeon of Monmouth in England, where goitre is endemic, has cured a number of patients, by the use of steady pressure, after the failure of other remedies.†

But I have found no general or local remedies so efficacious as the extract of cicuta. Indeed, for several years, I have depended chiefly upon the use of this medicine, and may declare that I have seldom had recourse to it in the early stage of bronchocele, without some benefit. I found by experience, that from the age of ten or twelve years up to twenty, and in cases where the goitre was large and spongy to the touch, and had not existed very long, that the cicuta was almost a certain remedy; but, on the other hand, when it occurred in adults beyond the age mentioned, and in old people, that although it sometimes diminished the size of the swelling, yet, in general, it was productive of no advantage. The *seton*, employed so frequently by the older surgeons, and recommended a few years since, by Quadri of Naples, I tried repeatedly in the case of a German boy from Lancaster, whose neck was covered with a lobulated goitre of enormous dimensions—without any other benefit than the copious discharge of a thin greenish fluid, which diminished

* Foderé, p. 115.

† London Medical Repository, vol. 8, p. 288.

the tumour for a time, and relieved the patient of the uneasiness occasioned by its pressure on the windpipe.

Within the last ten years, a remedy for goitre has been introduced into practice, by Dr. Coindet of Geneva, which has excited, in a great degree, the attention of the profession in almost every European country, and in America. I allude to the preparation termed *iodine*. The reports of Coindet in favour of this medicine were soon fully confirmed by many other continental surgeons; and its reputation rose speedily to the highest pitch; strange as it may seem, however, its decline has been almost as rapid as its rise, being now considered, in the estimation of many practitioners nearly inert, and by others pronounced a most virulent poison. But from all the statements made on the subject, we have, I think, fairly a right to infer, that it is a medicine of great power, calculated, in some cases, to produce a very strong impression on goitrous and other tumours, as many well attested cases decidedly show; and that, on the other hand, it is followed occasionally by tremendous symptoms, and even death. Again, it is equally certain, that upon other patients not the slightest impression has been made by its use, either upon the tumour or upon the constitution of the individuals who have taken it, sometimes for months together, and in the largest doses. My own experience in its use is very limited, but judging from this and from the reports made to me concerning it by my colleagues in the Alms House Infirmary, I should feel inclined to doubt its efficacy. Still it is possible we may have been deceived, either by the bad quality of the medicine, or by other circumstances. Lastly, it may be stated, that Dr. Coindet himself, has abandoned the *internal* use of the remedy, and merely employs it in the form of inunction, from which he states that he has derived very beneficial results.

Bronchocele sometimes disappears spontaneously. Occasionally, the tumour is removed suddenly. Several examples of the sort are related by Alibert. In one instance, during the French revolution, a woman was seized with a fit of melancholy, and a large bronchocele, from which she had suffered exceedingly, disappeared with the utmost rapidity.*

Bronchocele may become so large as to endanger suffocation.

* Alibert's *Nouveaux Elémens de Therapeutique*.

In this case, *extirpation*, an operation first recommended by Celsus, has been resorted to, and sometimes with success. But such favourable terminations are extremely rare—as many of the older, and some of the modern French and English surgeons have sufficiently proved. Palfin, in his *Surgical Anatomy*, relates the case of a lady of rank in Paris, who perished from hemorrhage, in consequence of the removal of a large goitrous tumour, by an adventurous surgeon, who undertook the operation in spite of the remonstrances of some of the most experienced practitioners. The operator had scarcely left the house, before the hemorrhage broke out, with tremendous violence, and destroyed the patient in a few minutes.* Gooch mentions three cases, in which the operation was performed contrary to his advice, and that of some other surgeons. Two of the patients lost their lives from hemorrhage, and the third was only saved by constant pressure, kept up day and night for the space of a week, by the fingers of several persons employed for the purpose.† Mr. John Bell mentions more than one instance, where surgeons have opened tumours arising from or connected with the thyroid gland, from which the flow of blood has been so copious, as to oblige them to abandon the operation and close the wound as speedily as possible.‡ Desault, upon one occasion, undertook to remove a bronchocele from the neck of a woman, but the blood issued with such rapidity, as to force him to stop and endeavour to secure the vessels by throwing a ligature around a considerable portion of the tumour which he had dissected up. The patient died in a very short time, in convulsions, occasioned, it was supposed, by irritation from the ligatures.§ Another case is recorded of a patient who had a large bronchocele, which was productive of no inconvenience to him, removed by the knife, by the advice of Desault, and contrary to the opinion of Baron Percy and Louis. It was found impossible to stop the blood, and the gentleman expired almost immediately. Many examples of a similar nature are recorded by Bonetus, Severinus, and others of the older writers. But, perhaps, the most remarkable operation of the kind to be found

* *Anatomie Chirurgicale*, tome ii. p. 313.

† *Chirurgical Works*, vol. iii. p. 158.

‡ *Principles of Surgery*, vol. iii.

§ *Dictionnaire des Sciences Medicales*, tome xviii. p. 556.

in the annals of surgery, was executed, a few years ago in Paris, by the celebrated Dupuytren, on a young woman who had laboured for a great length of time under an enormous bronchocele, which interrupted respiration and deglutition to such a degree, as almost to destroy her. The patient had presented herself frequently at the Hotel Dieu, in expectation of having the tumour removed by the knife. At several consultations held on her case by the most distinguished surgeons of Paris, it was unanimously determined, that no operation could be performed with any prospect of success. The tumour, however, still continuing to increase in size, and the entreaties of the patient for its removal becoming more urgent, Dupuytren, at last, consented to engage in the undertaking. By slow and cautious dissection he succeeded in detaching the left side of the tumour, without dividing any of the large arteries, veins or nerves of the neck. The thyroid arteries, in particular, which were very much enlarged, were each drawn out and tied with two ligatures before they were cut. The right portion of the tumour was then removed, in a similar manner, and the whole operation completed, with the loss only of a few spoonsful of blood. But the patient suffered extremely, as the operation was necessarily protracted, and the dissection carried on among parts of the utmost delicacy and sensibility. She never recovered from the shock communicated to the nervous system, and expired in thirty-five hours after the operation.*

It would appear, from these details, that the extirpation of even a small tumour of the thyroid gland, is attended with difficulties which should dismay the most expert and enterprising surgeon. Cases are recorded, however, where operations of the kind have been attended with success. Foderé states that a barber relieved his wife of a very large bronchocele by excision. The same author mentions two other instances within his own knowledge, where Giraudi, an adventurous surgeon of Marseilles, succeeded in curing his patient, by the same means.† Desault dissected out the right side of an enlarged thyroid gland of a female patient in the Hotel Dieu, who recovered without a

* Dictionnaire de Sciences Medicales; also, Pelletan's Clinique Chirurgicale, vol. 1, p. 215.

† Traité du Goitre, &c. p. 118.

bad symptom in a month after the operation.* Two cases of successful extirpation of bronchocele are detailed by Dr. Harris, of New York. In the first case the tumour was not larger than a pullet's egg, in the second it was of considerable size. "About three months since," says Dr. Harris, "an application was made to me by a lady from South Carolina. I think the bronchocele was full as large as any I had ever seen. The tumour had been increasing for twenty-two years. It extended from the chin, which it buoyed up, along the trachea, until it descended an inch, or perhaps more, under the breast bone, and spread laterally a medial distance to each ear."† No hemorrhage of consequence followed either operation, and both patients recovered in a very short time. There is great reason, however, to believe, from the histories of these cases, that the tumours neither constituted a part of the thyroid, nor were connected with it. But, from all the information I have been able to collect, on the subject of the removal of this gland by the knife, I am inclined to believe that less danger would attend its excision, as respects hemorrhagy, than is commonly imagined. Our knowledge of the means of arresting hemorrhage has been greatly improved within a few years; and it will be seen, that Dupuytren, by adopting a practice long ago recommended and employed with the greatest success, in this country, by Dr. Physick (the tying of large arteries before they are cut) was enabled to extirpate an enormous bronchocele, with the loss of only a small quantity of blood. But I very much question the propriety of attempting the removal of a goitrous tumour, in any case, inasmuch as I conceive that hemorrhage is less to be dreaded than the inflammation and irritation which follow the operation. Under ordinary circumstances, the tumour may attain a very large magnitude, without endangering the patient's life or producing much inconvenience; and if it should increase to such a degree as to render death inevitable, there is very little probability that the patient can be saved by so severe an operation as must necessarily be encountered.

But although I would not recommend the excision of the thyroid gland, there is another operation to which I would

* *Surgical Works*, vol. 1, p. 257.

† *New York Medical Repository*, vol. 11, p. 242.

not hesitate to resort in case of necessity. I allude to the tying up of the great arteries in the vicinity of the tumour, from which it chiefly derives support. Mr. Thomas Blizzard, of London, was the first, I believe, to execute the operation. The thyroid arteries on each side of the neck, were included in a ligature, and the tumour diminished, in the course of a week, one-third in size. The patient, however, did not recover, but died from repeated secondary hemorrhage, occasioned by an attack of hospital gangrene. But he lived long enough to evince the propriety and practicability of the operation.* In 1818, a similar operation was performed by Professor Walter, of the University of Landshut, on a man twenty-four years of age, who had an enormous bronchocele, from which he suffered extremely. The inferior thyroideal artery of the left side was taken up, and at the end of a fortnight the left portion of the tumour had diminished so much in bulk as to induce the operator to include the superior thyroid of the right side in a ligature. No inconvenience followed either operation, and the bronchocele, in a short time, almost disappeared, leaving behind only the elongated skin, which hung from the neck in the form of an empty sack.†

* Burns' Surgical Anatomy, p. 202.

† Bulletin de la Société Médicale d'Emulation, 1818.

SECTION VI.

Torticollis, or Wry Neck.

FROM exposure to cold, from rheumatism, twists of the neck, or strains of the platysma-myoides, and sterno-mastoid muscles, from the cicatrices of burns, &c., the head is sometimes drawn to one side, or towards the shoulder or sternum, in such a way as to produce great deformity. Occasionally, the disease arises from paralysis; in other instances, it proceeds from some defect or malformation of the vertebræ of the neck. The clavicular is oftener affected than the sternal portion of the sterno-mastoid muscle; each, however, is liable to be converted into a substance resembling gristle. The whole of the muscle also is shortened, has an indurated, stringy feel, and is painful to the touch. Great pain is frequently experienced upon attempting forcibly to restore the head to its natural position.

Treatment of Wry Neck.

When the disease depends upon paralysis of the muscles, or upon malformation of the vertebræ, it may be looked upon, generally, as incurable; but when it arises from morbid contraction of the fibres of the platysma-myoides, or sterno-mastoid muscles, an operation will, in many instances, effect a cure. It should be done in the following manner. The patient is seated on a chair, and his head supported by an assistant standing be-

hind him. An incision is then made two or three inches long, in the course of the muscular fibres, through the integuments; and the contracted portion having been fairly exposed, the handle of a knife, (or a small curved spatula,) is carried behind it, in order to protect the vessels beneath. By one or more cuts of a bistoury, the muscle is next separated, and when this is effectually done, the head may immediately,* in most cases, be restored to its natural situation. Very frequently it happens, that several strings of muscular fibres, in different places, require to be cut across. In such cases, the surgeon must persevere until he has loosened the whole. After the operation, the head should be supported in its proper place by bandages or a stock of leather, and the edges of the wound, for some time, kept separated by lint. Sometimes, especially in females, it may be deemed expedient, in order to obviate deformity arising from the cicatrix, to pinch up the contracted portion of the muscle, along with the skin covering it, and divide it with a narrow and sharp-pointed bistoury. Dupuytren has related a case in which he succeeded perfectly by adopting this plan. Professor Jorg, of Leipsic, has attempted the cure of wry neck by machinery, and sometimes, it is said, with success.

On Diseases and Accidents of the Œsophagus and Trachea, consult—*Pelletan's Clinique Chirurgicale*, tom. 1—*Desault's Works*, by Smith, vol. 1—*C. Bell's Operative Surgery*, vol. 2—*C. Bell's Surgical Observations*, vol. 1—*Lawrence on some Affections of the Larynx, &c. in Medico-Chirurgical Transactions*, vol. 6—*Chevalier's Case of Croup*, vol. 6, of *Medico-Chirurgical Transactions*—*Monro's Morbid Anatomy of the Gullet and Stomach*—*Burns' Observations on the Surgical Anatomy of the Head and Neck*—*Hopkins' Case of a Shot in the Trachea*, in *Potter's Medical Lycæum*. In this case, the shot was removed from the trachea of a young lady, by her mother, who, without apprizing the patient of her intention, suddenly seized her while lying over the edge of a bed, and forced her head and shoulders towards the floor. The shot, being carried by this movement towards the glottis, was instantly discharged.

On Bronchocele, consult—*A Memoir concerning the Disease of Goitre, &c.*, by Benjamin Smith Barton—*Reeve on Cretinism in Edinburgh Medical and Surgical Journal*, vol. 5—*Foderé Traité du Goitre et du Cretinisme*—*Dictionnaire des*

* I performed an operation, several years ago, upon a young girl, sixteen years of age, whose head had been drawn for several months towards the right shoulder, from a contraction of the clavicular portion of the sterno-mastoid muscle. As soon as the muscle was cut across, the head was instantly restored to its natural position, and has so remained ever since.

Sciences Medicales, vol. 3—*Gooch's Chirurgical Works*, vol. 2—*Baillie's Series of Engravings to illustrate Morbid Anatomy*—*Alibert's Nosologie Naturelle*—*Gibson on Bronchocele*, in vol. 1, of the *Philadelphia Journal of the Medical and Physical Sciences*—*An Essay on the Effects of Iodine on the Human Constitution, with Practical Observations on its Use in the Cure of Bronchocele, Scrofula, and the Tuberculous Diseases of the Chest and Abdomen.* By W. Guirdner, M. D. 8vo. London, 1824—*Medical Researches on the Effects of Iodine, in Bronchocele, Paralysis, Chorea, Scrofula, Fistula Lacrymalis, Deafness, Dysphagia, White Swelling, and Distortions of the Spine.* By Alexander Manson, M. D.

On Wry Neck, consult—*C. Bell's Operative Surgery*, vol. 1—*Gooch's Chirurgical Works*, vol. 2—*Sharp's Treatise on the Operations of Surgery*—*B. Bell's System of Surgery*, vol. 5—*Boyer's Traité des Maladies Chirurgicales*, tom. 7—*Kirby's Cases, with Observations on Wry Neck, &c.*—*Cooper's First Lines of the Practice of Surgery*, vol. 1, p. 558; in which will be found an Engraving and Description of Jorg's Apparatus.

CHAPTER IV.

DISEASES OF THE THORAX.

GUN-SHOT and other wounds of the chest, emphysema, collections of purulent matter, and of blood, mammary abscess, carcinoma of the breast, fractures of the ribs and sternum, aneurism of the aorta, caries of the spine, having been already treated of in other places, it only remains to notice hydrothorax, and to describe the operation necessary for its removal, after the physician has exhausted his skill in the trial of medicines.

SECTION I.

Hydrothorax, or Dropsy of the Chest.

THIS disease is either idiopathic or symptomatic. The former is very rare, the latter frequent. Idiopathic hydrothorax generally occupies one side of the chest only, and is frequently unaccompanied by dropsy in other parts of the body. The pleura itself is seldom much diseased, and merely contains a serous fluid. The lung of the affected side is collapsed, and the patient complains of great difficulty of breathing.

Symptomatic hydrothorax is exceedingly common, and is characterized by the following symptoms. The patient finds it difficult, if not impossible, to lay in the horizontal position, or on the unaffected side. His respiration is hurried and laborious, pulse irregular, thirst incessant, urine diminished and high-coloured. In addition to these symptoms, a troublesome cough and palpitation of the heart usually attend the disease. One of the most certain symptoms, however, is a sensation resembling the movement of water within the chest. This par-

ticular sensation may often be discovered by the surgeon himself, while the patient is in the erect position, by forcibly striking the chest, and still better by the use of the stethoscope. A collection of water in the pericardium may give rise to all the symptoms of common hydrothorax. Sometimes both sacs of the pleura are filled with fluid. In other instances, the cavities are occupied by hydatids. The most common causes of symptomatic hydrothorax, are intemperance, gout, asthma, anasarca, pleurisy.

Paracentesis Thoracis.

This operation is seldom resorted to until the case is hopeless—a sufficient explanation of the unfavourable termination that generally awaits it. When performed early, however, and under favourable circumstances, it is calculated to afford great relief, even if it should fail to remove the disease. The situation most favourable for the evacuation of the fluid, is between the sixth and seventh ribs, counting from above downwards. Having placed the patient nearly in an upright position, with his back supported by pillows or by an assistant, and the head and shoulders directed backwards, the surgeon makes an incision three inches long, with a small scalpel or bistoury, through the integuments, cautiously penetrates the layers of the intercostal muscles (keeping close to the upper edge of the seventh rib to avoid the intercostal artery) and makes an opening through the pleura large enough to admit a full-sized cannula or gum elastic catheter, which should be introduced as soon as the water begins to flow. Care must be taken, however, not to push the cannula too far, lest its extremity irritate the lungs, and excite coughing. This happened to me during the winter of 1824, in the Alms House Infirmary, in a case of hydrothorax under care of Dr. Jackson, and brought on immediately a most severe cough, that distressed the patient exceedingly. If a very large quantity of fluid has collected, it will be improper to remove the whole of it at a single operation—lest the patient suddenly

die from the pressure being taken off from the heart and lungs. When both sides of the chest are occupied by the fluid, an operation will be required on each side: but they should never be performed simultaneously, inasmuch as the lungs generally collapse as soon as the chest is opened, in which case the patient must necessarily die. After the fluid has been evacuated the lips of the wound should be closed by sticking plaster, and made to unite. Should the water accumulate again, as it often does, the operation may be repeated. "The operation for empyema, or paracentesis, is seldom resorted to in this country," says Dr. Jackson, "or England, for the relief of morbid effusions into the chest. Though of greater frequency, on the continent of Europe, yet, in comparison with the practice of former periods, it appears to be falling into disusage. The nature of these effusions, and their causes, are widely different. The operation is not calculated to afford equal benefit in all cases in which they exist, while, in many, it is wholly useless. From a recurrence to it without discrimination, it has, no doubt, often proved of no service, and may have been sometimes of disadvantage; and, in consequence, the benefits that may be obtained from the apposite performance of this operation, have been too much underrated. Many striking instances of unequivocal relief, and some complete cures in desperate cases, are on record, as having been obtained by these means; nor can it be questioned, that, employed with judgment, it will seldom fail to afford relief from distressing symptoms, will often protract life, and, sometimes, prove auxiliary to the completion of a perfect cure. The operation itself is simple, unattended with much hazard, being but little more formidable than the opening of a large abscess, and, when an effusion into the chest is clearly indicated, may, with perfect propriety, be performed, merely with a view to alleviate the distress and suffering of the patient, even when it holds out no expectation of an ultimate recovery."

See *B. Bell's System of Surgery*, vol. 5, p. 188—*Laennec on the Diseases of the Chest*—*S. Cooper's First Lines of the Practice of Surgery*, vol. 1, p. 584—*Archer's Case of Paracentesis*, in vol. 1 of *Transactions of the King's and Queen's Colleges of Physicians in Ireland*—*Jackson's Case of Effusion into the Chest, in which Paracentesis was performed*, in the *Philadelphia Journal of the Medical and Physical Sciences*, vol. 10, p. 19.

CHAPTER V.

DISEASES OF THE ABDOMEN.

WITH few exceptions, the surgical diseases of the abdomen are as numerous, diversified and important, as those of any other part of the body. Many of them, too, are extremely intricate, and will require all the student's industry and skill to unravel them. This is strikingly the case with hernia, which, from the complicated anatomical relations of that disease, its extraordinary frequency, the numerous varieties of the complaint, the distinct modes of treating each, recommended by some surgeons, and condemned by others equally eminent, the necessity, upon many occasions, for delicate operations, called for, often, upon the spur of the occasion, and without a moment's warning, should be sufficient, as a distinguished writer has remarked, "to infuse fear into the heart, and agitation into the conscience of all who presume to call themselves qualified surgeons, without having first duly considered every thing relating to so important a branch of their profession."

In the ensuing sections, I propose to consider dropsy of the belly, poisons in the stomach, and the principal varieties of hernia. Abscess of the liver, aneurism of the abdominal aorta, lumbar abscess, and wounds of the abdomen, have been already treated of in their proper places.

SECTION I.

Ascites, or Dropsy of the Abdomen.

IN the commencement, this disease is marked by difficulty of breathing, cough, dryness of the skin, constipation of the bowels, diminished secretion of urine, loss of appetite, prostration of strength. These symptoms are soon succeeded by general fulness of the abdomen, and by a sense of fluctuation easily perceived by laying one hand on the belly, and striking it with the other.

Ascites, for the most part, is the consequence of organic disease of the viscera of the abdomen, particularly scirrhus of the liver, pancreas, or spleen. Sometimes it arises from an accumulation of water in the cavities of the pleura or pericardium, at other times it follows an enlargement of the mesenteric glands. In general, the fluid is contained in the sac of the peritoneum, and sometimes accumulates in prodigious quantity.

*Paracentesis Abdominis.*

By the internal use of volatile tincture of guaiacum, squill, gamboge, calomel, digitalis, elaterium, and other similar medicines, I have frequently succeeded in removing, entirely, dropsy of the belly. The disease, however, often terminates fatally for want of a timely operation. There are two situations in which

this may be performed—mid-way between the spine of the ilium and umbilicus, or in the linea alba. The former has of late years been mostly abandoned, owing to the thickness of the muscular parietes, and to the epigastric artery, from irregular distribution, having sometimes been wounded. A trocar, either round or flat, is the instrument commonly used in this operation; or a common lancet may be employed, as advised by Dr. Physick. Preparatory to the operation, the abdomen should be surrounded by a piece of flannel, broad enough to cover its whole surface, and sufficiently long to go twice round, the ends of which are split in three or four places. The middle of the bandage is placed over the front of the abdomen, and the ends are crossed upon each other, and left hanging on each side. Having marked the spot in the linea alba best adapted to the operation—about two or three inches below the umbilicus—the surgeon makes a slit in the flannel, corresponding to the part, and through this penetrates with the trocar or lancet, the integuments, tendons and peritoneum. The instrument being withdrawn, the water instantaneously follows the puncture, and in proportion as it flows, assistants placed on each side of the patient tighten the flannel by pulling at its ends. This serves the purpose of keeping up the general support of the abdomen, and prevents the patient from fainting. If a very large quantity of fluid has accumulated, it may, perhaps, be imprudent to draw it all off at once, lest the patient be too much exhausted. On the contrary, the better plan will be to close the orifice from time to time, until the whole is evacuated; after which, the opening may be permitted to heal. Should the surgeon prefer a common lancet for the operation, he must be prepared with a flat cannula, corresponding to the size of the instrument, and introduce it into the opening immediately after the lancet is withdrawn. Sometimes the flow of water is suddenly interrupted by the intrusion of a particle of fat within the cannula. When this happens, the obstacle should be removed by a probe. The operation of paracentesis abdominis, is one which in general requires frequent repetition. Incredible quantities of fluid have been drawn from some patients at once, or at separate operations. Many patients sink under the disease in a few weeks or months; others live for as many years, and experience temporary relief from operations. A few recover perfectly.

It sometimes happens that pregnancy so closely resembles abdominal dropsy as to be mistaken for it, and cases are related in which the uterus has actually been tapped. The following remarks on this subject by Sir Astley Cooper are well calculated to put the young surgeon on his guard. Speaking of encysted dropsy, he says, "I will here mention two circumstances, in one of which my character was exposed to considerable risk; of the other I was informed by a medical man who was invited to witness the operation. In the first case I was desired to see a lady who I was told laboured under dropsy. When I entered the room I saw a tall delicate female, with an immense abdominal swelling, giving a distinct sense of fluctuation. I requested the physician accoucheur, whom I met, to examine if the lady was not with child; he said he thought it was unnecessary, as the fluctuation was very distinct, but that he would do so and let me know the result in a few days. I heard no more of her for a week, and then I learned that she had been put to bed on the morning following my visit. I would not have performed the operation of paracentesis for the universe. The circumstances which were told me of the other case were as follow: a surgeon in a country town called upon another surgeon, and said, 'I am going to tap a woman to-morrow; perhaps your young gentlemen would like to be present.' As it was an operation they had never witnessed, they most readily accepted the invitation: they were shown into a room in which the patient was already prepared to undergo the operation; she was sitting at one end with her abdomen bare. The surgeon, then, taking his trocar and cannula, went to some distance, and walking up to the patient with the trocar presented, he charged, as it were with a bayonet, and plunged it into the abdomen; then withdrawing the trocar with an air of triumph, it was with no small chagrin he found not a drop of water escape; but, however, still undismayed, he withdrew the cannula, and again renewing his attack, he a second time introduced the trocar into the abdomen, but was equally as unfortunate as before, in finding that no water followed. Waiting a few moments, he withdrew the cannula, and turning round to the gentlemen, he said, 'You may do her up;' by which he meant they might apply the bandages; and he added, 'This, gentlemen, is an operation which you probably

never saw before, and which most likely you may never see again. This is what we call the operation of dry tapping!"*

The encysted, or ovarian dropsy, differs essentially in character and situation from common ascites. The latter is contained in the bag of the peritoneum, in the greater number of instances, in contact with the intestines; the former is confined to the ovarium, and originally contained in separate cells, the partitions of which are afterwards broken down or absorbed. A few of these cells, however, generally remain. The fluid of ovarian dropsy, also, is not commonly so thin and transparent as that of ascites. It is generally thick, tanacious and turbid, of a brown or yellow colour, and often resembles sero-purulent matter. From an enormous tumour of this description, which I opened some years ago, were discharged several gallons of fluid, of the consistence and colour of honey. But, in other cases, I have drawn off large quantities of perfectly transparent serum. When the ovarian dropsy becomes so extensive as to occupy the abdomen, it is very difficult to distinguish it from ascites; but after an operation the walls of the ovarium can be distinctly felt, in shape of a tumour large as a child's head, on one side of the abdomen.

See C. Bell's Operative Surgery, vol. 1, p. 318—Dorsey's Surgery, vol. 2, p. 364.

* Sir A. Cooper's Lectures on Surgery, by Tyrrell, Vol. II. p. 378.

SECTION II.

Poisons in the Stomach.

ACCIDENTALLY, or by design, poisons are often taken into the stomach, and, according to their particular quality and quantity, produce, in greater or less time, violent symptoms or death. Poisons from the mineral, vegetable, and animal kingdoms, are all capable of these effects. With few exceptions, however, mineral poisons are more active and deleterious than either vegetable or animal. The principal mineral poisons are arsenic, corrosive sublimate and some other preparations of mercury, acids, and alkalies, lead, tartrite of antimony, and lunar caustic. These, when taken into the stomach, operate by exciting violent inflammation, or by producing excessive vomiting, palsy, or convulsions. Arsenic and corrosive sublimate give rise nearly to the same symptoms: these are swelling of the tongue, extreme thirst, a burning sensation throughout the gullet, violent spasmodic pain in the stomach and intestines, incessant vomiting and purging, and the evacuation of viscid mucus mixed with blood. If relief be not speedily afforded, cold sweats, faintings, twitchings of the limbs succeed and destroy the patient in a few hours. When examined after death, the stomach and œsophagus exhibit marks of violent inflammation, and are sometimes perforated with numerous holes.

Among the *vegetable* poisons most deleterious, may be enumerated opium, cicuta, aconitum, hyoscyamus, digitalis, belladonna, hellebore, savin, laurus cerasus, and many varieties of fungus or mushroom. These, when introduced into the stomach in large quantity, occasion palpitation of the heart, stertorous breathing, vertigo, dimness of sight, torpor, distention of the stomach, convulsions and death. In addition to these symptoms, opium and laudanum, in large doses, have the peculiar power of inducing

profound sleep, which generally terminates in apoplexy, paralysis, or death.

The *animal* poisons capable of producing violent symptoms, or fatal consequences, by being taken into the stomach, are comparatively few in number. The principal are cantharides, and certain varieties of fish.* Prussic acid, which belongs both to the animal and vegetable kingdoms, is a most subtle poison, and, sometimes, even in very small quantity, produces instantaneous death. Cantharides is more protracted in its operation, but is capable of inducing tremendous symptoms, and not unfrequently proves fatal. Some poisonous fish, when eaten, destroy life in a few hours.



Treatment of Poisons in the Stomach.

When the nature of the poison taken into the stomach can be ascertained, it may be possible sometimes, by antidotes, to obviate its deleterious effects. A large quantity of albumen, or white of eggs, for example, is looked upon as the proper corrective for corrosive sublimate; lime water, charcoal, or carbonate of magnesia for arsenic; muriate of soda for lunar caustic; calcined magnesia for the mineral acids; acetic acid for the alkalies. It must be understood, however, that in general neither these nor any other articles of similar description are calculated to produce very beneficial effects, and that our reliance must be placed mainly upon speedy and copious vomiting, and upon the removal of the poison by means of the gum elastic tube and syringe. The last is a remedy of modern origin, and one of

* Poisonous fish are by no means uncommon in some parts of the West Indies. Those reputed the most deleterious are the yellow billed sprat, dolphin, the rock fish, barracuda, smooth bottle fish, the king fish, the gray snapper, the white land crab, and the conger eel.

immense importance. By whom the idea was first suggested, is not positively known. Renault, however, in his work on poisons,* expressly recommends an apparatus (somewhat similar to the one now in use) for removing arsenic from the stomach. Dr. Monro, afterwards, in his thesis,† gave drawings of instruments for the removal of laudanum from the stomach, and at the same time published a case in which the experiment had been tried—though without success. Quo laudani effectus leniores essent ei in ventriculum, instrumento in tab. XIV. depicto, per magnam aquæ tepidæ quantitatem injeci, faucibus simul per oris speculum diductis.”‡ It remained, however, there is reason to believe, for Dr. Physick to prove the utility of the invention; for until the successful issue of the experiment performed by him in 1812, on a child of three months old, poisoned by laudanum,§ little importance was attached by the profession either to Renault’s or Monro’s proposal. Since that period every apothecary’s boy in Philadelphia has become fully acquainted with the operation, which, perhaps, has been performed hundreds of times with the most favourable result. Strange as it may appear, European, or at least British, surgeons are just becoming acquainted with the practicability of the operation, for we find from the statements of a Mr. Read, and from remarks in the periodical work called the “Lancet,” that the proposal has been considered by Sir Astley Cooper, Messrs. Scott, Jukes, and other surgeons, as perfectly novel, and this so late as the year 1822!!

When called to a patient suffering from poison, whether corrosive sublimate, arsenic, or any other article of the kind, the surgeon should resort immediately to a powerful emetic, and, if this does not answer, to the gum elastic tube, (an instrument about two feet in length, and three-eighths of an inch in diameter,) and by means of a common pewter syringe applied to its upper extremity, inject into the stomach a quantity of tepid water. The water, mixed with the contents of the stomach, should be

* *Experiences sur les contre Poisons de l’Arsenic*, 8vo.

† *De Dysphagia*, Edin. 1797.

‡ *De Dysphagia*, p. 95.

§ See *Eclectic Repertory*, vol. 3, p. 111.

immediately afterward withdrawn, and a fresh supply thrown in, and by this alternate injection and evacuation, the stomach may in a little time be thoroughly scoured out, the poison removed, and the patient recovered—provided there has not been too great delay. The common syringe and tube I prefer to the more complicated and expensive instruments of Jukes and Read—after repeated comparative trials with each. Of late years, however, several instruments for pumping out the stomach have been invented, less complicated and more effectual than the ones just referred to. In particular, a syringe invented by Dr. C. Mathews,* of this city, is worthy of the praise which has been bestowed upon it. English surgeons, especially, I presume, must have been pleased with it; for soon after an account had been published of it in the London periodicals, Mr. Weiss, a celebrated cutler, manufactured one upon the same *principle* exactly, but without reference to the source from which he, probably, derived it. Mr. Weiss' pump has since been introduced into general practice, and is, certainly, a very beautiful, simple, and useful instrument. But an instrument still more simple,† equally useful, and infinitely cheaper, has been invented lately by Dr. Goddard of this city; an account of which, I regret to say, has been received too late for insertion in this place.

Consult *Monro's Morbid Anatomy of the Human Gullet, Stomach, and Intestines*, p. 79—*Thomas' Modern Practice of Physic*, edit. 7, p. 311—*Dictionnaire des Sciences Medicales*, tom. 43, p. 525—*Orfila on Poisons*—*Chisholm on the Poisons of Fish*, in vol. 4, of the *Edinburgh Medical and Surgical Journal*, p. 393—*Brodie's Observations on the Action of Poisons on the Animal System*, in *Transactions of the Royal Society of London*, 1812—*Bostock's Experiments, Showing that a Mineral Poison may produce sudden and violent Death, and yet be incapable of Detection in the Contents of the Stomach*, in *Edinburgh Medical and Surgical Journal*, vol. 5, p. 14—*Account of a New Mode of extracting poisonous Substances from the Stomach*, by P. S. Physick, in the *Eclectic Repertory*, vol. 3, p. 111 and 381—*Read's Appeal to the Medical Profession, on the Utility of the Improved Patent Syringe, &c.*—*The Lancet*, vol. 1, No. 8.

* See American Medical Recorder for 1826.

† See Journal of Franklin Institute, for April, 1834.

SECTION III

Hernia.

A PROTRUSION of any of the abdominal viscera, covered by the peritoneum, through natural or preternatural apertures in the tendinous or muscular parietes, may be denominated hernia. The term has been extended, though improperly, to several other diseases bearing no analogy to the one under present consideration.

Hernia is a very common disease; so much so, that one-eighth of mankind, it has been imagined, is troubled with it—a proportion, however, immensely overrated. Certain general appellations expressive of the particular condition or contents of a hernial tumour, are employed by most modern surgeons—reducible, irreducible, and strangulated hernia, enterocele, epiplocele, and entero-epiplocele. By *reducible* hernia is understood a tumour easily replaced by pressure, or by laying the patient in the horizontal position, but descending again as soon as the pressure is discontinued, or the upright posture resumed. The term *irreducible* hernia implies permanent protrusion from adhesion between the sac and its contents, or from extraordinary bulk. *Strangulated* hernia is that state of the disease in which the parts are confined by stricture, and are liable to mortify, unless the stricture be speedily removed. When the protrusion consists of intestine alone, the disease is denominated *enterocele*; when it contains omentum merely, it is called *epiplocele*; and, if intestine and omentum together, *entero-epiplocele*. Herniæ are, also, designated according to the situation they happen to occupy. Thus, we have *bubonocoele* or inguinal hernia, *oscheocoele* or scrotal hernia, *merocele* or crural or femoral hernia, *exomphalos* or umbilical hernia, congenital hernia, ventral

hernia, ventro-inguinal hernia, and several other varieties of comparatively rare occurrence.

Every hernia is furnished with a peritoneal investment, or *sac*; this is pushed before the protruded viscera, and passes through a natural or preternatural opening, to the margins of which it speedily forms an intimate adhesion. That portion of the sac communicating directly with the abdomen is called its *mouth*; its lower extremity, or that most remote from the internal surface of the belly its *fundus*, and the part immediately surrounded by the aperture in the tendinous parietes, its *neck*. The sac, although originally thin, as the rest of the peritoneum, soon acquires an increased thickness, and in hernia of long standing, is sometimes greatly condensed. On the other hand, it is frequently found attenuated to an extreme degree, or entirely wanting—as the result of absorption. That it is susceptible of extreme extension, is proved by those enormous hernial tumours, so common in very warm climates, and sometimes met with in this country.

The *causes* of hernia are very numerous, and are either exciting or predisposing. Severe exercise on foot, or on horseback, lifting heavy weights, playing on wind instruments, vomiting, costiveness, strictures of the urethra, the whooping-cough, crying, parturition, tight clothes, jumping, often produce the complaint either immediately or remotely. Among the predisposing causes of the disease, hereditary conformation and preternatural laxity of the abdominal apertures, may be considered the most common.

Reducible hernia is distinguished from other varieties of the disease by the following symptoms. The tumour, as already mentioned, descends in the erect, and retires within the abdomen during the recumbent position, or when pressure is made upon it. If the sac should contain intestine, a peculiar rumbling or gurgling noise will be perceived both by the patient and surgeon, at the moment the gut slips into the abdomen. The tumour will also be tense and elastic to the feel. Omentum, on the contrary, communicates to the finger a doughy sensation, and is with greater difficulty restored to the abdomen. Besides these indications, a reducible hernia may be distinguished from other diseases by the circumstance of its being larger after a meal than when the stomach and intestines are empty, and by an impulse being com-

municated from the tumour to the surgeon's finger when the patient is directed to cough. If suffered to increase, the reducible hernia may in time become enormously large, and the patient will not only experience great disorder of the digestive organs, but his life will be endangered by strangulation of the gut.

Irreducible hernia may arise from three different causes—from adhesion between the sac and its contents—from the formation of membranous bands across the sac—and from an extraordinary enlargement of the omentum, or great increase in volume of the intestines. The two last causes are more common than the first. Effusion of lymph upon the inner surface of the sac, and upon the outer surface of its contents, gives rise to the bands that intersect the intestine and omentum, and fasten them at different points to each other. When the omentum has resided for a long time in a hernial sac, it is apt to become enlarged and indurated, and in this state cannot pass through the neck of the sac and be restored to the abdomen. Sometimes a mass of hardened omentum serves as a truss, and prevents the descent of the intestines. Slow inflammation, from neglect, from blows upon the tumour, and other injuries, is the most frequent cause of hernia being changed from the reducible to the irreducible state.

The symptoms of *strangulated* or incarcerated hernia, are, in most instances, so strongly marked, as to admit of no deception; yet it happens, now and then, that the disease is confounded with *ileus* and other intestinal affections. If, from irregularities of diet, violent corporeal exertions, injuries, or other causes, the contents of a reducible or irreducible hernia should become constricted, the fæcal evacuations will be suppressed, the patient will complain of general soreness of the abdomen, of pain around the navel, resembling the sensation produced by a tight cord, of sickness of the stomach, and of severe pain in the tumour itself. To these symptoms are speedily added, vomiting of bilious or stercoraceous matter, hiccup, a quick, hard pulse, an increase of tension in the abdomen, cold sweats, great anxiety of countenance. If by this time the patient does not experience relief, a remarkable change in the symptoms will soon take place. The pulse becomes small and thready, the patient feels suddenly easy, the tumour when pressed upon crackles beneath the fingers, and assumes a leaden colour. To these succeed

enormous distention of the abdomen, a fluttering, intermittent pulse, and death. When examined by dissection, the intestine will be found of a dark brown or chocolate colour, interspersed with black or mortified spots, and coated in particular places with a brownish or bloody lymph. The omentum is seldom altered in appearance. The sac contains, in proportion to its size, and the duration of the strangulation, more or less of a bloody fluid. At the strictured part, the intestine is generally ulcerated or detached. Throughout, the peritoneum exhibits marks of high inflammation, and in numerous places the intestines are glued together, and their surface streaked with red vessels. It might, perhaps, be supposed that a stricture upon the omentum *merely*, would not give rise to constipation and the other symptoms of strangulation above enumerated. Experience, however, proves the contrary. With regard to the length of time strangulation may continue, much will depend upon the age and size of the tumour, and upon its contents. Recent and small herniæ, generally speaking, are more dangerous, and terminate sooner, when strangulated, than the old and large. An intestinal hernia, also, runs its course quicker, and is more violent in its symptoms than an omental hernia. Some strangulated herniæ prove fatal in six or eight hours; others continue for as many days. The disease, when left to itself, is not invariably mortal. On the contrary, the parts exterior to the stricture, in some instances, mortify, and are thrown off in the form of slough, an artificial anus is established, and the patient recovers. The seat of the stricture in strangulated hernia must depend upon the particular situation the hernia happens to occupy.



General Treatment of Hernia.

Reducible, irreducible, and strangulated herniæ all require distinct and particular modes of treatment.

For reducible hernia, an appropriate *truss* is the only remedy, and the sooner this is applied the better. Formerly an opinion

prevailed that such instruments were not adapted to infants; the error has been amply rectified by modern experience, and much mischief thereby prevented. Trusses are either elastic, or non-elastic: the latter are now seldom employed, and never can be to advantage. A well constructed steel truss often effects a perfect cure, especially in children and young subjects, by exciting a degree of inflammation sufficient to agglutinate the sides of the sac, or the edges of the opening through which the hernia has passed. To accomplish this purpose, great attention must be paid by the surgeon in adapting the instrument to the parts, and by the patient in wearing it without intermission. The best mode of fitting a patient with a truss, is to try a number of instruments, and select the one that adapts itself best to the hollows and projections about the abdomen and pelvis, and can be worn with the least inconvenience. When no opportunity of selection offers, a measure may be taken by means of annealed wire, doubled and passed around the body, taking care to leave the wire an inch or two longer than the size of the patient—to allow for the stuffing of the instrument. A well contrived truss will fit accurately in every part, and set closely to the body, neither bulging in particular places, nor binding too closely. Every patient should be provided with a spare truss—in case of accident. To prevent the pad of the truss from imbibing perspiration and becoming hard, a bit of calico, muslin, or rabbit skin should be placed between it and the tumour. With a view, also, of obviating rust, to which the spring is very liable, the instrument may be thickly covered with durable leather, or some similar material, and with oil-cloth, or gum elastic, when the patient has occasion to bathe. A truss, to derive full benefit from it, must be worn night and day, and for months and years together. Particular varieties of truss will be noticed when the different species of hernia are described.

Irreducible hernia, particularly that variety of it dependent upon adhesion between the sac and its contents, very seldom admits of relief. Cases are recorded, however, by Arnaud, Ledran, and Hey, of the diminution and final restoration to the abdomen, of immense hernial tumours, by low diet, blood-letting, purging, and confinement, for many months together, to the horizontal position. In most cases, a suspension of the tumour

by a bag truss, and strict attention to diet, are all that can be done.

For *strangulated* hernia, various remedies have been employed—such as blood-letting, purging, the cold and warm baths, opium, fomentations, and poultices, the application of cold, the taxis, tobacco injections, and an operation. The three last only are to be relied upon. By *taxis* is understood an effort to restore the protruded intestine or omentum, by manual pressure, to the cavity of the abdomen. This should be attempted always before any other plan, and is frequently successful. To increase the chance of success, the surgeon must endeavour to relax the abdominal muscles as much as possible—by elevating the shoulders and pelvis with pillows, bending the patient's legs on his thighs, and his thighs on the pelvis, and at the same time drawing them towards each other. Upon the tumour, steady, but not violent pressure, should then be exerted and kept up unremittingly with the fingers or hands for half an hour. If this fail, the taxis must be discontinued, lest it increase the inflammation in the protruded parts. The surgeon may next have recourse to the tobacco enema, which, (as it is a very powerful and dangerous medicine, if incautiously administered,) should be carefully prepared by infusing a dram of tobacco in a pint of boiling water for a quarter of an hour. When cool, the liquor may be strained, and one-half of it thrown up the rectum by a syringe, and the remainder half an hour afterwards, should the first prove inefficient. The effect of tobacco, thus administered, is to prostrate the system, excite the action of the intestines, and relax the abdominal muscles. As soon as these ends are accomplished, a slight effort, in the way of taxis, will often succeed in overcoming the stricture, and in restoring the parts to the abdomen. If the tobacco fail, the knife is our only resource; but in the use of this, the surgeon must be governed by the particular seat of the hernia—as will be explained in the ensuing sections.

SECTION IV.

Inguinal Hernia.

AFTER the general account given of hernia and its treatment, it will be proper to consider the varieties of the disease, the principal of which are inguinal, crural, umbilical and congenital hernia. To each of these, it will be necessary to prefix a short account of the anatomy of the parts.

When the integuments of the abdomen are turned back, a thin but compact sheet of cellular substance, described by modern anatomists under the name of *superficial* fascia, will be found to cover the whole surface of the abdominal muscles. Not only does it cover these muscles, and their tendons, but extends upwards to the chest, and downwards to the thighs, and, in fact, may with propriety, perhaps, be said to form a sort of general investment to the body. Its attachment to Poupart's ligament, and to the surface of the spermatic cord, is particularly close. On the surface of the fascia, and running over Poupart's ligament towards the umbilicus, an artery and vein may be observed. These are branches of the external pudic, and from being concerned in the operations for strangulated inguinal and crural hernia, should be noticed in the dissection of the parts. Besides these vessels, numerous inguinal glands will be seen lying beneath the fascia, and intermingled with its fibres.

Under the superficial fascia, lies the tendon of the *external oblique* muscle. The lower margin of this constitutes Poupart's ligament, which extends from the anterior superior spinous process of the ileum to the pubes; and as it approaches this part, splits into two columns, the upper of which is inserted into the symphysis, the lower into the tuberosity of that bone;

leaving between them a triangular space, called the external abdominal ring, out of which emerges the spermatic cord.

When the tendon of the external oblique is cut away, or turned down upon the thigh, the *internal oblique* muscle is brought into view. The lower margin of this arises from the outer half and inner surface of Poupart's ligament, and passing above the spermatic cord, in a vaulted form, is fixed by a tendon into the symphysis pubis. From the edge of the internal oblique, the *cremaster* muscle arises, is inserted into the spermatic cord, and descends with it into the scrotum.

The lower edge of the transversalis muscle, like that of the internal oblique, arises from the outer portion of Poupart's ligament, crosses over the spermatic cord, and uniting its tendon with that of the internal oblique, is inserted into the pubes.

These three muscles—the external oblique, the internal oblique, and the transversalis—serve to cover in the abdomen, and support the viscera. From the manner, however, in which the two last are formed, (being deficient as it were in part, or not wholly inserted into Poupart's ligament,) this support would be very inadequate, were it not for the co-operation of an additional structure—the *fascia transversalis*.

This fascia consists of condensed cellular membrane, lines the internal surface of the transversalis muscle, and is interposed between it and the peritoneum. Its extent is very considerable, for it not only covers the whole of the lower part of the abdomen and passes out along with the femoral vessels upon the thigh, but ascends to the diaphragm. In this fascia, an opening is left for the passage of the spermatic cord—called the internal abdominal ring.

The *spermatic cord*, consisting of arteries, veins, lymphatics, nerves, the vas deferens, and a membranous sheath, enters the internal abdominal ring—which is situated about half an inch above Poupart's ligament, and midway between the spine of the ileum and symphysis pubis—and taking a course inwards and downwards, passes along the edges of the internal oblique and transversalis, and finally emerging at the external ring, descends nearly in a perpendicular direction into the scrotum. Along the under and inner side of the spermatic cord, and between it and the pubes, passes the *epigastric* artery, a vessel

materially concerned in the operation for strangulated inguinal hernia.

From the above account of the structure of the parts immediately concerned in inguinal hernia, it will appear—that there are two abdominal rings, the *external*, formed by a splitting of the fibres of the external oblique tendon, the internal, by an opening in the fascia of the transversalis muscle. To make this structure more intelligible to the student, it will be proper to observe that these rings are distant from each other, in most full-grown subjects, about an inch and a half, that between them there is a canal for the passage of the cord, that the cord enters the internal ring, passes obliquely downwards under the internal oblique and transversalis muscles, (not through them, as formerly supposed,) until it reaches the external ring, after which its course is perpendicular. To understand the reason of the cord not perforating the internal oblique and transversalis, it will only be necessary to remember that these muscles are not attached to the whole of Poupart's ligament, but only to the outer half of it, and consequently that they may be said to be wanting from that part as far as the symphysis pubis.

In most instances, the hernial sac and its contents enter the internal abdominal ring anterior to the spermatic cord, and having reached the origin of the cremaster muscle, passes between it and the cord. Sometimes, however, the cord is placed on the side of the sac, at other times on its front. The epigastric artery runs along the under and inner side of the sac, and between its mouth and the symphysis pubis. In immediate contact with the sac, and on its anterior surface, is spread out, from pressure, the cremaster muscle, which forms one of the coverings of the sac. Above the cremaster is the superficial fascia, and next to it the integuments. If a dissection, therefore, is made of the coverings and contents of the inguinal hernia, commencing at the skin, the parts will be presented in the following succession—the integuments, superficial fascia, the cremaster muscle, the hernial sac, omentum or intestine, and perhaps both.

The *symptoms* of reducible, irreducible, and strangulated inguinal hernia do not differ from those of hernia in general, and these have been already pointed out in the preceding section. But it is important to distinguish between this disease, and others

bearing to it some similitude. Inguinal, or rather scrotal hernia, may be confounded with hydrocele, cirsocele, enlarged testis, and some other affections. From hydrocele, it may be distinguished by the circumstance of the tumour commencing above the abdominal ring, and descending towards the scrotum, whereas hydrocele always begins in the lower part of the scrotum, and gradually ascends. Cirsocele sometimes bears a striking resemblance to scrotal hernia, but it may be distinguished from it by placing the patient in a recumbent position, pressing firmly upon the upper part of the ring, and then directing him to rise, when, if it be cirsocele, the tumour will reappear, and of an increased size; if hernia, it will be retained within the ring until the finger be removed.

An inguinal hernia is sometimes contained within the canal leading from the internal to the external ring. It is then called *concealed* inguinal hernia. As in cases of this description there is commonly no external tumour, the surgeon should be on his guard, and suspect the existence of this disease, if the symptoms of strangulation be present. The hernial sac in such cases is generally covered, in addition to the usual investments, by the tendon of the external oblique, and edges of the internal oblique and transversalis. Scrotal hernia in shape is commonly pyriform, and in size is very various, descending in some instances to the patient's knees, at other times is not much larger than a natural scrotum. Occasionally, the disease is met with on both sides. Males are more subject to the disease than females, and when it occurs in the latter the tumour bears the same relation to the round ligament that it does to the spermatic cord in the male.

Treatment of Inguinal Hernia.

For reducible inguinal, or scrotal hernia, an appropriate elastic truss should be selected. Above most instruments of this

description, I prefer that of Wright of Liverpool, formed upon the principle of Whitford's truss, described in the work of Mr. Lawrence on hernia. The peculiarity of these instruments consists in their not forming a perfect oval, but in being straight or nearly so behind, where they cross the small of the back, and rising from the posterior part of the pelvis, and descending in front towards the groin. Of the truss of Salmon and Ody, (commonly called Hull's truss,) I have also a favourable opinion. This, instead of passing entirely around the pelvis, is formed of a semicircle of steel, with a pad at each extremity—one of which is adapted to the groin, the other to the back. In fitting a patient with a truss for inguinal hernia, the surgeon should take care to adapt the instrument to the lower part of the internal ring; for if it be placed, as is too often done, upon the external ring, it not only presses upon the cord, gives unnecessary pain, and injures the function of the testicle, but does not answer the purpose of supporting the hernia. Every patient should habituate himself to return his own hernia and to apply the truss; and the most convenient time for effecting this is in the morning before he rises, as the intestines and omentum, during the night, generally retire within the abdomen.

The *irreducible* scrotal rupture subjects the patient, when it attains a large size, to great inconvenience, by impeding copulation and by arresting the flow of urine, which, from the penis being buried among the integuments, excoriates the parts and gives rise to small abscesses. To prevent the growth or increase of the swelling, a *bag truss* is the only remedy.

Strangulated inguinal or scrotal hernia, should the taxis and tobacco injection fail, will require an operation, and the sooner this is performed, after it has been determined upon, the better; for there is reason to believe that many lives have been lost by delay, and few, if any, from the operation itself. The patient being placed upon a table of ordinary height, with his thighs somewhat separated, and each foot resting upon a chair, the surgeon sits before him, and grasping the tumour with one hand, makes an incision with the other, commencing at the upper part of the tumour, and extending downwards nearly to its base. Having divided the integuments, a branch of the external pudic artery generally springs, and may require the ligature. Immediately beneath the integuments, lies the superficial fascia: this should

be divided by successive touches of the knife, until the cremaster muscle appears; the fibres of which may be elevated carefully by the dissecting forceps, or by running the directory beneath them, until the whole are cut through, and the sac exposed. To open this without risk of injuring the intestine, a portion of it may be pinched up and rubbed between the fingers previously to its division. As soon as the sac is opened, a quantity of fluid gushes out, and part of the intestine or omentum appears at the opening. Fluid, however, is not invariably met with, and it is highly important that the operator should be aware of this, otherwise he might, in expectation of finding it, continue to penetrate with the knife, until he wounds the intestine. The opening in the sac should be enlarged upwards and downwards to the extent of two or three inches, and if its contents are found in a proper condition to be returned into the abdomen, the next step of the operation is to carry the fore-finger of the left hand upwards between the sac and protruded parts, and search for the stricture, which will be found either at the edges of the external ring, the internal ring, or the mouth of the sac. In very old and large herniæ, the external ring is the most common seat of the constriction, but, in ordinary cases, the internal ring. By gentle pressure with the fingers upon the intestine or omentum, these parts may sometimes be restored without dividing the stricture; if the attempt fail, however, the operator then introduces a common curved probe-pointed bistoury, (the edge of which, with exception of half an inch of its extremity, is covered by a piece of riband or muslin,) with its flat surface between the sac and its contents, and with the fore-finger as the guide, carries its point beneath the stricture, turns up the edge of the instrument, and divides it. A very slight incision, even the eighth or sixteenth part of an inch in extent, will be often sufficient to liberate the parts. The moment this is accomplished, repeated and gentle efforts should be made to return them to the abdomen, after which the edges of the wound must be brought together and retained by adhesive straps. In the course of three or four hours after the operation, should the patient not have a stool within that time, a dose of castor oil must be administered. During the cure, the patient should be confined to bed, and not suffered to rise until the parts are so completely cicatrized, as to

bear the pressure of a truss—an instrument still more necessary after an operation for strangulated hernia, than before.

In dividing the stricture, in all cases of strangulated inguinal hernia, whether seated at the external or internal ring, or at the mouth of the sac, there is one rule extremely important to observe—to carry the knife directly upwards, (a practice first suggested by Rougemont, and afterwards adopted by Sir Astley Cooper,) by which we avoid wounding the epigastric artery. If, in the ordinary situation, for example, of this variety of hernia, the stricture be divided upwards and inwards, or towards the linea alba, and the incision prolonged to any extent, the epigastric will, almost to a certainty, be cut across. On the other hand, if the knife be carried upwards and outwards towards the ilium, and the hernial sac should descend, as it sometimes does, on the inner side of the epigastric, (constituting the variety of hernia called *Ventro-Inguinal*,) this vessel may possibly be divided. It is proper to observe, however, notwithstanding these precautions, that there are few examples of fatal hemorrhage from wounds of the epigastric, although the vessel has been cut in numerous instances by awkward and careless operators.

With regard to the condition of the intestine or omentum, it may be observed—that if mortified spots appear on the former, they should be included in a fine ligature before returning them to the belly; and that if the omentum be in an indurated state, and form too large a protuberance to admit of repassing the ring, it should be retrenched, taking care to tie up any particular vessels that may spring, instead of including the whole mass in a ligature, as was formerly practised.

Sir Astley Cooper, and some other surgeons have recommended, in large herniæ especially, to divide the stricture on the outside of the sac—leaving the sac unopened. To this plan, however, there are many objections.

The operation for small, or *concealed* inguinal hernia, does not differ materially from that of the common variety of the disease.

If the operation for strangulated inguinal hernia has been so long delayed as to permit the parts to fall into gangrene, and they are found in this condition by the surgeon after having

opened the sac, he should not think of pushing them, in this state, into the abdomen, even if he could effect it, because they would then act as extraneous bodies, and excite irritation. By the time, however, the process of sloughing is completed in the parts exterior to the stricture, it generally happens that the parts within the abdomen or its immediate vicinity are united by adhesion to the internal surface of the ring, and therefore, that the protrusion could not be returned without previously breaking up those adhesions, upon which, indeed, the safety of the patient must now in a great measure depend.

Some surgeons have attempted to cure inguinal and other varieties of hernia *radically*—by relieving the stricture, returning the protruded parts, and afterwards dissecting up the hernial sac, and either restoring it to the abdomen, or removing it entirely, and tying its mouth with a ligature. The practice, I conceive, is seldom justifiable. Many years ago I performed the operation, but the case terminated fatally. Experience proves, moreover, that a new sac, even if the patient recover, is almost sure to form.

SECTION V.

Femoral Hernia.

THE contents of a femoral or crural hernia, instead of passing through the abdominal rings, are protruded beneath Poupart's ligament through an opening termed the *crural* ring. This ring is bounded on the outer, or iliac side, by the femoral vein, on the inner or pubic side, by Gimbernat's ligament; anteriorly, by Poupart's ligament, and posteriorly by the pubes. Poupart's ligament arises from the spine of the ilium, and is implanted by a broad insertion into the symphysis pubis, into the tuberosity of the pubes and into the ligament of the pubes over the linea ileo pectinea. By this last insertion a sharp crescentic edge is formed, the concavity of which looks towards the crural vein, and is supposed by most writers, to contribute mainly to the constriction in cases of strangulated crural hernia. From having been particularly described by Gimbernat, a Spanish surgeon, it is frequently called *Gimbernat's* ligament. There are two margins to Poupart's ligament, an anterior and posterior, the former of which is straight, the latter concave, in the vicinity of the pubes.

The *fascia lata* of the thigh, as it approaches Poupart's ligament, divides into two portions—the *iliac* and *pectineal*, (sometimes called *sartorial*.) The former is connected to Poupart's ligament throughout the greater part of its extent; the latter is attached to the pubes, covers the muscles that spring from that bone, and unites with the iliac portion below, at the spot where the vena saphena major enters the femoral vein.

In thickness and strength the iliac portion of the fascia lata greatly exceeds the pectineal portion. It lies, moreover, considerably above the plane of the latter, and covers the femoral vessels, the anterior crural nerve, and the iliacus internus and psoaë muscle. Towards the pubes its edge is concave, and on this account

was denominated by Burn's, of Glasgow, the *falciform process*. Its superior horn received from Mr. Hey the appellation of *femoral ligament*, and is at the present day commonly known under the name of *Hey's ligament*. "It has already been stated," says Colles, "that the iliac portion of the fascia lata passes before the femoral vessels. We observe, in this part of its course, that it loses somewhat of its strength and firmness of texture; however, it generally retains a good deal of its ligamentous nature even when it has reached the pubic side of these vessels; except in the immediate neighbourhood of the vena saphena, where it differs but little from the cellular substance. Having passed before the femoral vessels, we find it now to descend on their pubic side; and here we see it attach itself very intimately to the pectineal fascia. This attachment is made in a straight line along the pubic side of the vein, from the place of insertion of the saphena to within a quarter of an inch of Poupart's ligament. At this place we observe that the line of attachment is curved; and having here formed a sweep towards the pubes, that the attachment now takes place in a line across the top of the thigh."* In most subjects, I have found the iliac portion of the fascia lata to consist of two layers, the innermost of which passed backwards behind the femoral vessels and united with the pectineal portion—leaving the falciform process double, like the margin of the cuff of a coat, and forming a round instead of a sharp edge.

Beneath the fascia lata, and in immediate contact with the femoral vessel, lies the *fascia transversalis*. This fascia, as formerly mentioned, under the head of inguinal hernia, not only lines the internal surface of the abdomen, but passes out upon the thigh under the posterior edge of Poupart's ligament. Descending in front of the crural artery and vein, it becomes united to their sheath and forms for them an additional investment. On the inner side of the crural vessels numerous absorbents may be observed passing through the transversalis fascia, on their way to the abdomen.

The *fascia iliaca* is but a continuation of the fascia transversalis, and differs from it only in situation. It lines the surface of the iliacus internus and psoæ muscles, adheres to the posterior margin of Poupart's ligament, descends with the cru-

* Surgical Anatomy, p. 68.

ral vessels to the thigh, and affords them posteriorly a strong investment. The union of the fascia transversalis and iliaca has been compared,* not unaptly, to a compressed funnel, the expanded part of which may be said to occupy the lower part of the abdomen and hollow of the ilium, while the pipe is represented by the prolongation which covers the femoral vessels and forms their anterior and posterior sheaths.

Although the space between the os innominatum and Poupart's ligament is filled up by the iliacus internus and psoæ muscles, these would not prove a sufficient barrier to the descent of a femoral hernia in various situations between the spine of the ilium and symphysis pubis. Such descent, however, is effectually guarded against, except at the crural ring itself, by the union of the fascia transversalis and iliaca. These fasciæ, indeed, are so closely connected with each other, with the posterior edge of Poupart's ligament, and with the surface of the psoas and iliacus internus muscle, and send off so many partitions between the crural artery and vein, and the adjoining parts, as to preclude effectually the escape of any of the viscera between them.

In dissecting the parts concerned in crural hernia, it is important to notice particularly the situation of the spermatic cord and epigastric artery. The former lies about half an inch from the mouth of the sac, above Poupart's ligament; the latter runs upon the outside of the hernial sac, and takes a course upwards and inwards on its way to the rectus muscle. Sometimes the *obturator* artery is sent off by the epigastric, and, running along the inner margin of the sac, and sometimes encircling it, is liable to be wounded, in performing the operation for strangulated femoral hernia, if the incision be prolonged too far inwards or towards the pubes.

A portion of omentum, or intestine, surrounded by the peritoneum, having entered the sheath of the femoral vessels, formed by the union of the iliac and transversalis fasciæ, passes along the inner edge of the crural vein, and carries before it the loose cellular membrane that naturally occupies the orifice of the crural ring. This membrane, (which has received from Sir Astley Cooper the name of *fascia propria*,) being pushed for-

* Colles, p. 63.

ward by the hernial sac, is carried along with it through one or more of the holes on the inner side of the crural sheath, and uniting with that sheath, the two fasciæ are "consolidated into one." Above the fascia propria will be found the superficial fascia and the integuments. If a dissection, therefore, be made of a femoral hernia, commencing at the surface of the bend of the thigh, the parts will be presented in the following order:—the integuments, superficial fascia, fascia propria, hernial sac. This last will be found resting in the hollow between the iliac and pectineal portions of the fascia lata, and, consequently, on the *outer* surface of that aponeurotic expansion. There is a variety, however, of femoral hernia, (in which the sac and its contents, not passing through the absorbent holes, is continued along the sheath of the femoral vessels,) *covered* by the fascia lata.

Women are more subject to femoral hernia than men, owing partly to the great breadth of the female pelvis, compared with that of the male. In shape, femoral hernia differs entirely from inguinal—its longest diameter being placed transversely with respect to the thigh. In general, moreover, the tumour is much smaller than that of the inguinal. On this account it is particularly liable to be confounded with other diseases, especially with enlargement of one or more glands of the groin, with varicose enlargement of the crural vein, psoas abscess, &c. In one patient, however, an old man in the Alms-House Infirmary, in 1833, I found the tumour as large as a child's head. Not unfrequently it is mistaken for inguinal hernia—owing to the tumour rising, from the oval space in the fascia lata, upon Poupart's ligament. The edge of this ligament may, however, in femoral hernia, always be traced above the tumour, while, in bubonocoele, it is below it. A very common symptom of reducible femoral hernia, is pain in the groin, from extending the thigh, which is sometimes so severe as to produce nausea and vomiting.



Treatment of Femoral Hernia.

The truss for *reducible* inguinal hernia, will answer also for femoral, provided the pad of the instrument be bent downwards

about an inch, in order that it may rest on the top of the thigh instead of the groin. *Irreducible* femoral hernia, when its contents consist chiefly of omentum, sometimes attains such a bulk as to prove very inconvenient to the patient. Under these circumstances, it has been advised by Sir Astley Cooper to apply a hollow truss to the tumour, (taking care previously to reduce the intestine,) with a view of promoting, by pressure, the absorption of the protruded parts.

Strangulated femoral hernia must be treated upon the principles formerly laid down. Instead, however, (in performing the operation of taxis,) of pressing the tumour directly upwards, as in strangulated inguinal hernia, the surgeon should first endeavour to disengage it from the edge of Poupart's ligament, by pressing it downwards and inwards; after which a slight pressure upwards will often succeed in restoring the omentum or intestine to the abdomen. If the taxis should fail, and an operation become necessary, there should be the least possible delay; for the disease runs its course with much greater rapidity than most other varieties of strangulated hernia.

The patient being placed horizontally on a table, the shoulders elevated by a pillow, the thighs somewhat relaxed and brought near to each other, the diseased parts shaved, and the bladder emptied, an incision is made, commencing about an inch above Poupart's ligament, and extending downwards to the middle of the tumour, through the integuments. At right angles with this another cut is made—the two representing in form the letter T reversed. The superficial fascia being exposed and carefully divided, the fascia propria is brought into view. This being likewise divided, more or less adipose substance will be generally found between it and the sac. To open the sac, which should next be done, without risk of injuring the intestine, (for in this variety of hernia there is seldom much fluid in the sac,) a portion of it should be carefully pinched up and rubbed between the finger, and divided by carrying the knife horizontally through it. As soon as the intestine, or omentum, is discovered, a finger may be introduced into the opening, and upon this a curved bistoury, with which the sac may be enlarged, to the extent, if necessary, of several inches. The next object of the operator will be to ascertain the seat of the stricture. This will be found either at Hey's ligament, in the crural sheath, at

Gimbernat's ligament, or in the mouth of the sac. When the hernial tumour is large, more or less constriction will always be made upon it by the falciform process of the fascia lata, and particularly by that portion of it called Hey's ligament. In ordinary cases, however, I am inclined to believe that the sharp posterior border of Poupart's ligament, or the ligament of Gimbernat, as it is called, contributes more than any other part to keep up the symptoms of strangulation. But be this as it may, the surgeon must proceed in his operation until he has removed every obstacle. With this view, passing the fore-finger of his left hand gently between the sac and its contents, he carries it upwards until he meets resistance. The bistoury should then be passed, with its flat edge towards the finger, until it is fairly within the strictured part, when its edge may be turned up and pressed lightly against the obstruction. If the parts are not sufficiently liberated to be returned by moderate pressure, the finger should be carried higher, and other obstructions sought for. These, if found, must likewise be divided, taking care in making each incision to carry the bistoury *upwards* and slightly *inwards*. The operator, if regardless of this rule, might, by prolonging his incision outwards, or upwards and outwards, injure the crural vein and epigastric artery. On the contrary, by directing the knife too far inwards or towards the pubes, the obturator artery, in case it should happen to spring from the epigastric and take an inward course, would be endangered. By the inward incision, moreover, there is great risk of wounding the intestines. Having relieved the stricture and restored the contents of the sac to the abdomen, the after treatment will not differ from that pointed out in some of the preceding sections.

SECTION VI.

Umbilical Hernia.

THE umbilical vein, and its two arteries, in the fœtus, perforate the tendons of the abdominal muscles about the centre of the linea alba, and leave an opening called the *umbilical* ring. Soon after birth these parts are consolidated, and a firm cicatrix is formed, externally, by the contraction of the integuments, internally by the peritoneum, and between the two, by the remains of the umbilical vessels. The ring being thus closed and fortified, protrusions of the abdominal viscera, in most subjects, are guarded against. Sometimes, however, it happens, that the ring is imperfectly closed, or its edges so weak, as readily to yield to any force the viscera may exert against it. Under these circumstances, an umbilical hernia will be produced. It is still a disputed point whether the protrusion takes place at the centre of the umbilical ring, or at its edges. Sir Astley Cooper inclines to the former opinion. There is reason to believe, however, that both occurrences are not unfrequent. Many of the older writers believed the umbilical hernia to be destitute of a sac or peritoneal covering, erroneously supposing that the umbilical vessels were naturally situated behind that membrane, and, consequently, that the abdominal contents were protruded through the imaginary opening, in the peritoneum, for the transmission of these vessels. The fact, however, that the arteries and vein, while on their way to the umbilical cord, lie between the abdominal tendons and peritoneum, has long been known. The inference, therefore, is not less plain than true,—that the umbilical, like most other varieties of hernia, is covered by a peritoneal sac.

There is some variety in umbilical hernia, according as it occurs in the infant at birth, in the young subject, or the adult.

The *congenital* umbilical hernia, as it is called, is often complicated with spina bifida, and with extraordinary enlargement of the liver and other abdominal viscera. The contents of the abdomen are protruded through the umbilical ring into a transparent bag, formed out of the cellular membrane that connects the vessels of the cord. So transparent, indeed, is this investment, that throughout the greater part of the tumour, the hernial sac may be distinctly seen.

The umbilical hernia of *young subjects* is, unlike the congenital variety, covered by the common integuments of the abdomen, and generally makes its appearance about the third or fourth month after birth. It seldom attains, unless very much neglected, a large size; indeed, in many instances, the tumour scarcely exceeds a common marble in bulk, and when pressed upon, readily retires into the abdomen; returning again, however, as soon as the pressure is discontinued. Its figure is commonly round. A fold of intestine generally occupies the hernial sac, and omentum is scarcely ever met with. The disease is often accompanied by disorder of the bowels and digestive organs.

Amongst *adults*, the most common causes of umbilical hernia are, pregnancy, laborious parturition, and inordinate fatness. Hence, women, and especially those who have borne many children, are the most subject to the disease. The tumour may, perhaps, remain stationary, or nearly so, for years; in the end, however, it is almost sure to attain considerable bulk, and sometimes exceeds in magnitude the patient's head. Nausea, eructations, constipation of the bowels, are very common attendants upon this variety of hernia. In general, the omentum constitutes a very large proportion of the contents of an old umbilical hernia, and the colon is oftener found in the sac than any other intestine.



Treatment of Umbilical Hernia.

Congenital umbilical hernia, provided there be no extraordinary deficiency of the tendinous parietes, or other morbid

complication, may be cured frequently by a well contrived bandage, or by surrounding the sac and integuments, (having previously reduced the intestine,) with a ligature—drawn with sufficient firmness to occasion the parts included in its embrace to slough, and the edges of the umbilical ring to cicatrize. The last is the most certain and expeditious mode of effecting a cure. Instead of the simple ligature, Dr. Hamilton, of Edinburgh, approximates the edges of the ring by silver pins and adhesive straps. His example, however, should not, I conceive, be imitated.

The ligature was frequently employed by the ancients, in the cure of umbilical hernia of *young subjects*, and, in modern times, has been extensively used and highly extolled by Desault. In several instances I have performed the operation with complete success, and with little pain or inconvenience to the patient. There is no risk in the operation, provided the surgeon succeeds perfectly in restoring the protruded parts to the abdomen, before he ventures to apply the ligature; which should be of considerable thickness and strength, and drawn so firmly as to ensure the speedy destruction of the parts surrounded by it. After the slough is detached, the sore that remains may be dressed with dry lint or some mild ointment until perfectly healed. For two or three months afterwards it will be proper to support the new-formed cicatrix by a compress or truss, to guard against its laceration and the consequent reproduction of the disease.

To the reducible umbilical hernia of *adults* the ligature is not adapted. In such cases the surgeon must depend upon a *truss*, which, so long as it keeps the intestine or omentum within the abdomen, will at least prevent the increase of the tumour, and may eventually, perhaps, by exciting a slow inflammation, effect a cure. Sir Astley Cooper, in small herniæ, prefers the common inguinal truss, which, if it form a perfect oval, will without difficulty adapt itself to the body, and furnish the requisite support to the tumour. For large umbilical herniæ, however, the trusses invented by Morrison, or Eagland, of Leeds, and described in most modern systems of surgery, will be found to answer a better purpose than any others. When the hernia is irreducible, and of very large dimensions, a hollow

truss, or a wide belt, carried under the tumour and over the patient's shoulders, may be resorted to advantageously.

Strangulated umbilical hernia very frequently proves fatal, as much from disorder of the intestinal functions, as from the strangulation. When the usual remedies fail, an operation should be resorted to. This may be done in the following way. An incision, several inches long, is made, very cautiously, through the integuments and superficial fascia, when the sac, if not absorbed, as is often the case, will appear. Into this a small opening should be made, from which fluid in considerable quantity generally issues. The opening may then be enlarged, and a finger carried upwards between the omentum and intestine as high as the umbilical ring. Upon the finger a bistoury is next carried through the linea alba, to the extent of an inch, which, in most cases, will relieve the stricture sufficiently to enable the operator without much difficulty to restore the parts to their former situation.

To guard against peritoneal inflammation, which is sometimes apt to follow the operation just described, Sir Astley Cooper, in two instances, adopted the following mode of procedure. "As the opening," says he, "into the abdomen is placed towards the upper part of the tumour, I began the incision a little below it, that is, at the middle of the swelling, and extended it to its lowest part. I then made a second incision at the upper part of the first, and at right angles with it, so that the double incision was in the form of the letter T, the top of which crossed the middle of the tumour. The integuments being thus divided, the angles of the incision were turned down, which exposed a considerable portion of the hernial sac. This being then carefully opened, the finger was passed below the intestine to the orifice of the sac at the umbilicus, and the probe-pointed bistoury being introduced upon it, I directed it into the opening at the navel, and divided the linea alba *downwards* to the requisite degree, instead of *upwards*."

Dr. Physick has proposed, in *strangulated* umbilical hernia, to make a crucial incision through the integuments, as far as the neck of the sac, then open the sac at its upper part to an extent sufficient to enable the operator to examine its contents, and reduce them, if possible, without dilating the umbilical ring.

Should the latter expedient, however, become necessary, the stricture must be divided on the outside of the sac. After the omentum and intestine are restored to the abdomen, a ligature should be drawn around the neck of the sac with a view of closing the cavity and obviating peritoneal inflammation. The late Dr. Wistar once performed the operation with success. In the case of a Mrs. N., a very respectable Jewish lady, I performed a similar operation about ten years ago. The tumour, however, was as large as a child's head, and had been strangulated several days before I saw the patient, and, on this account, the operation did not succeed. The patient, too, was advanced in years, extremely corpulent, and had long suffered from derangement of the functions of the stomach and intestines. Under these circumstances, no operation, probably, would have answered the purpose, even if performed in the very commencement of strangulation.

SECTION VII.

Congenital Hernia.

THIS, as its name implies, is met with at birth, or, as generally happens, a short time after birth. It differs from common inguinal hernia, in being destitute of a distinct peritoneal sac, and in being lodged in the tunica vaginalis, in contact with the testicle. "In a common rupture," says Mr. Samuel Cooper, "the viscera push out with them a portion of the great bag of the peritoneum, which thus forming one of the most regular investments of the displaced bowels, is called the hernial sac. But in the congenital inguinal hernia, the sac, in which the viscera lie, is not thrust forth in this manner, by the displaced bowels: on the contrary, it is a production of peritoneum originally formed and placed ready for the reception of the testes on their descent from the loins, but into which the bowels are sometimes accidentally propelled, before the passage leading into it from the belly is duly closed. The congenital inguinal hernia, therefore, differs from the generality of ruptures in having no hernial sac, formed and produced by the peritoneum being thrust forth from the belly by the displaced bowels themselves. There is, indeed, one very uncommon species of scrotal hernia, contained in the tunica vaginalis, yet included, also, in a common hernial sac, so that the protruded bowels neither lie in contact with the preceding membrane, nor with the albuginea. This particular case was first noticed and described by the late Mr. Hey. It seems to be formed after the communication of the cavity of the peritoneum with that of the tunica vaginalis has been obliterated, but previously to the closure of the passage lower down."* In most respects, the

* First Lines of the Practice of Surgery, vol. ii. p. 23, edit. 4th.

anatomy of congenital hernia resembles that of the inguinal. The spermatic cord, and the spermatic artery lie behind the hernia. The testicle, from being surrounded by the intestine or omentum, can seldom be distinctly felt.

Congenital hernia sometimes resembles hydrocele so closely as to be mistaken for that disease—owing to water accumulating in the abdomen and passing along with the hernia into the tunica vaginalis. It is very important to distinguish the one disease from the other; which may generally be done by placing the patient in the horizontal position, returning the hernial contents to the abdomen, and there retaining them by a finger pressed upon the abdominal ring. In the mean time, the water alone remaining in the tunica vaginalis may be easily distinguished by its transparency and peculiar feel.

Treatment of Congenital Hernia.

The reducible congenital hernia, if attended to soon after the disease is discovered, may be readily cured by a well constructed truss—inasmuch as there is a strong disposition in the tunica vaginalis at the ring to close of itself after the descent of the testicle. A spring truss can seldom be used in a child immediately after birth, but a linen compress, covered by a bandage, if well applied, will generally answer every purpose; and after the lapse of a few months a truss with a weak spring may be employed. It sometimes happens that the testicle is detained at the ring, and that the omentum or intestine is placed above or along side of it. In such a case a truss should not be applied, as it will either prevent the descent of the testicle, or bruise the hernial contents.

Strangulated congenital hernia, if not relieved by the usual remedies, will require an operation, which differs from that of common inguinal hernia, chiefly in this particular—that the in-

cision of the sac should never be prolonged further than the upper part of the testicle, in order to obviate inflammation of the tunica vaginalis, to which this membrane is particularly prone.

That inflammation is propagated, more readily, to the peritoneum within the abdomen, after the operation for strangulated *congenital* hernia than for that of castration, is owing to the tunica vaginalis, in the former case, being continuous with the peritoneum, whereas in the latter it is closed immediately after the descent of the testicle. In certain quadrupeds (as in the horse) the tunica vaginalis communicates directly with the abdomen and is continuous with the peritoneum. If, therefore, in castrating such animals, care be not taken to *sear* the cord and edges of the tunica vaginalis, by hot irons, as practised, with propriety, by farriers, death will be very apt to follow. Twenty years ago, I performed the operation, to oblige a friend, on a colt, and tied up the vessels as I would have done in the human subject. Violent inflammation followed and the animal was saved with great difficulty. Sir A. Cooper mentions a similar instance. Searing obliterates the passage between the abdomen and tunica vaginalis, and produces the same effect as *natural adhesion* in the human subject.

In large congenital herniæ that have long remained irreducible, Sir Astley Cooper advises the return of the parts without inspection, provided the stricture can be removed without opening the tunica vaginalis.

SECTION VIII.

Artificial Anus.

WHEN the operation for strangulated hernia has been too long delayed, and the intestine has mortified, it sometimes happens that an artificial anus is formed. In such cases the inflammation, instead of extending throughout the peritoneum and producing the patient's death, is limited to the neighbourhood of the stricture, and, terminating in the adhesive stage, glues the sound portions of intestine to the hernial sac. This adhesion becomes firmer and firmer, in proportion as the sloughing process going on in the protruded parts advances, until the sloughs are thrown off and fæces are discharged externally. By this provision of nature, effusions into the cavity of the abdomen are, in nine cases out of ten, effectually guarded against. As in every case of hernia the intestine is doubled upon itself, it follows that the two portions must lie parallel, or nearly so, with each other, and that when an artificial anus is formed, an intermediate ridge or projection will be the result. To the free admission of the fæces from the upper to the lower part of the canal this ridge will prove, in general, a serious obstacle; in most cases, indeed, there is a total cessation of fæcal discharge by the rectum; so much so that the intestine is constantly empty, or, at most, contains only a glairy mucus. After a time, however, fæces in small quantity occasionally pass through the lower part of the canal, and are discharged from the rectum. This is owing, in part, to the contraction of the external orifice of the artificial anus, and at the same time, to an enlargement of the passage between it and the orifice of each gut. As soon, therefore, as the fæces leave the upper intestine, they fall into a "funnel-shaped" cavity, and meeting with some resistance from the contracted mouth of the opening in the integuments, are propelled by a circuitous route towards the orifice of the lower gut.

An artificial anus, whether induced by a wound of the abdomen, or by hernia, is a very grievous disease, not only subjecting the patient to great inconvenience, but endangering his life. Most patients, labouring under the infirmity, are troubled with colic and other derangement of the intestinal functions. Besides, they have no control, for want of a sphincter, over the fæcal discharge. A prolapsus from one or both openings of the intestine, is by no means uncommon, and is sometimes exquisitely sensible. Artificial anus, when situated high up, or among the small intestines, is apt to terminate fatally—from inanition.

Treatment of Artificial Anus.

Nature will often make surprising efforts towards restoration, and is sometimes abundantly successful. Aware of this, the surgeon must not be officious, but patiently wait, so long as there is any prospect of a favourable termination. In the mean time, the patient should be supplied with a common truss, the pad of which must be broader than usual, and covered with a piece of bladder or oiled skin. This serves the purpose of restraining the fæces, and at the same time contributes, by blocking up the external opening, to direct them to the lower intestine. If it should be found, however, after the lapse of months, that there is no prospect of amendment, an operation may be attempted for the relief of the sufferer. The indication to be fulfilled by this is to overcome the ridge-like barrier situated between the two intestines, and which prevents the direct descent of the excrement from one to the other. Desault, with this view, introduced into each orifice of the gut, plugs of lint or linen, and by these means frequently succeeded. A more expeditious, effectual, and less troublesome operation, was proposed and executed by Dr. Physick, between the years 1808 and 1809. A crooked needle, armed with a ligature, was passed for some distance within the orifice of one gut, and brought out at the other—traversing in its passage the coats of each. The ends

of the ligature were then tied at the external opening, and formed a loose loop. This being suffered to remain for a week, caused the sides of the intestines to adhere to each other. Through the consolidated ridge, thus formed, an incision was afterwards made, and a direct communication established between the upper and lower intestine. An operation, similar to that of Dr. Physick, was afterwards performed by the late Baron Dupuytren, in Paris, and to him the merit of the proposal is awarded by European writers—without the slightest foundation.

Dr. Physick's claim to priority, as respects the operation for artificial anus above described, having, as just mentioned, been contested by European surgeons, the following statement on the subject from the able pen of Dr. Benjamin H. Coates, of this city, must carry conviction to the mind of every unprejudiced person.

“ John Exilius, a Swedish sailor, aged nineteen years, was admitted into the Pennsylvania Hospital on the morning of the 20th of October, 1808, affected with a congenital hernia. He stated that he had passed the last fourteen days without having had a stool, and that on the 29th, he had been affected with stercoraceous vomitings. These were renewed after his admission. After several other means had been employed to produce a reduction of the hernia, the operation was proceeded to at half past three o'clock the same afternoon, by the late Professor Wistar, in the presence of Dr. Physick. The sac being opened, the intestines were found firmly adherent to the testicle, and partially so, but with equal firmness to the abdominal ring, so as to account for the impossibility of effecting a reduction by the taxis—they appeared to be a part of the ilium. A perforation existed in the side of one of them, of sufficient magnitude to permit the discharge of a considerable amount of fæces. There were, however, no marks of mortification found, and the opening appeared to be the product of mere ulceration. After the removal of the stricture, and the application of a dressing, a dose of laudanum was administered, and the patient was returned to his bed. Much enlargement of the abdomen continued, accompanied with great general restlessness, and but a small quantity of the fæces was discharged from the wound, though various means were employed to procure their expulsion. On the 22d and 23d, stercoraceous vomiting returned, and it was not till the 23d that

much relief was obtained. This was the result of a copious discharge produced by the injection into the bowel of an infusion of senna. On the 24th, Dr. Wistar divided a small portion of the tendon of the transversalis abdominis, as well as of the neck of the sac, from which ensued much greater facility for the escape of the fæces. On the 30th of October, the patient, by the regulations of the hospital, came under the care of Dr. Physick. On the 24th of December, the projecting portion of the intestine was cut off close to the ring. This was done under the expectation that the open orifices thus left in the intestine would gradually be retracted within the abdomen. On applying a ligature to a divided mesenteric artery, severe pain was produced in that cavity, which was relieved by rhubarb, laudanum, and aniseed. After waiting some time, and finding that retraction did not take place, as hoped for, another process was resorted to. A roll of waxed linen, such as is used in making bougies, and of the size of the fore-finger, was bent double and each end introduced into one of the orifices of the intestine. The dresser then pressed the angular part of this tent backwards, in such a manner as to approximate the adherent intestine to a straight position. So much pain, of a kind similar to colic, was produced by this pressure, that the plan was necessarily abandoned. The two ends of the intestine were found, by a careful examination, to adhere to each other for some distance, and the form, thus presented, has been compared in this case to that of a double-barrelled gun. The next method proposed by Dr. Physick, was to cut a lateral opening through the sides of the intestine where they were adherent. But not knowing the extent of the adhesion inwards, he thought it necessary to adopt some preliminary measure for ensuring its existence to such a depth as might admit of the contemplated lateral opening without penetrating the cavity of the peritoneum. By introducing his finger into the intestine through one orifice and his thumb through the other, he was enabled to satisfy himself that nothing intervened between them but the sides of the bowels. He was thus enabled, without risk, to pass a needle, armed with a ligature, from one portion of the intestine into the other, through the sides which were in contact, about an inch within the orifices, which ligature was then secured with a slip-knot. This operation was performed on the 28th of January, 1809. The ligature was merely drawn sufficiently tight to ensure the

contact of those parts of the peritoneal tunic which were within the noose. When drawn tighter, it produced so much pain in the upper part of the abdomen, of a kind resembling colic, that it became necessary immediately to loosen it. The ligature, in this situation, gradually made its way by ulceration through the parts which it embraced, and thus loosened itself. It was at several periods again drawn to its original tightness.

After about three weeks had elapsed, concluding that the required union between the two folds of peritoneum was sufficiently ensured, Dr. Physick divided with a bistoury all the parts which now remained included within the noose of the ligature. No unfavourable symptom occurred in consequence. On the 28th of February, the patient complained of an uneasy sensation in the lower part of the abdomen, and on the 1st of March he extracted with his own fingers some portions of hardened fæces from his rectum. On the 2d of March, two or three evacuations were produced in this manner. On the 3d, an enema, consisting of a solution of common salt, was directed to be given twice every day. The first of these occasioned a natural stool, about two hours after its administration. The same effect was produced on the 4th, 5th, and 6th, and the discharges from the orifices in the groin now became inconsiderable. Adhesive plasters, aided by compresses, were employed, not only to prevent the discharge of fæces from the artificial opening, but with the additional object of procuring the adhesion of the sides. This last effort was unsuccessful. On the twenty-fourth of June, an attempt was made to unite them by the twisted suture. Pins were left in for three days, and adhesion was, in fact, effected; but owing to the induration of the adjacent parts, the wound again opened. On the 27th of July, a truss of the common construction, furnished with a very large pad, and surmounted by a large compress, was applied to the wound. By these means the discharge of fæces from the groin was completely prevented, and the patient had regular evacuations per anum, except when from improper diet or cold, he became affected with diarrhœa. At such times, a small portion of the more fluid matter escaped by the sides of the compress. Not satisfied with this state of things, Dr. Physick made several attempts to improve the patient's condition. On the 2d of August, a mould of the parts was taken in plaster of Paris, and being covered with buckskin,

was employed as a pad for the truss. This expedient answered extremely well, as long as the patient continued in the same posture in which the mould was made; but as soon as the form of the parts was altered by a change of position, fæces escaped from the orifice. A bandage was then applied to the body, furnished with a thick compress, and having that part of it which crossed the patient's back formed of elastic, extensible wire springs, such as are used in suspenders. This, also, however, proved ineffectual. The truss, with a compress and a large pad, stuffed in the common way, was then reapplied, and found to answer completely the purpose of preventing the discharge of fæces, the hope of an entire closure of the orifice being abandoned. On the 10th of November, he was discharged from the hospital in good health and spirits, and applied himself with very good success, to acquire the profession of an engraver.”—

Dupuytren has since invented a forceps of peculiar construction, called *enterotome*, for the purpose of bruising and breaking down by force the sides of the two intestines, and in this way opening a passage from one to the other. Dr. Physick's operation, it appears to me, in every respect, merits the preference.

On Hernia, Consult—Pott's *Works*, by Earle, vol 2—Hey's *Practical Observations in Surgery*, edit. 3—*The Anatomy and Surgical Treatment of Inguinal and Congenital Hernia*, by Astley Cooper, fol. Lond. 1804—Ditto *the Anatomy and Surgical Treatment of Crural and Umbilical Hernia*, part 2, 1807—Lawrence on *Ruptures*, edit. 3—Scarpa's *Treatise on Hernia*, translated from the Italian, by John Henry Wishart, Edinburgh, 1814—J. Cloquet, *Recherches Anatomiques sur les Hernies*, 1817—*A Treatise on Surgical Anatomy*, part the first, by Abraham Colles, Philadelphia, 1820—C. Bell's *Surgical Observations—Drawings of the Anatomy of the Groin*, by William E. Darrah, fol. Philadelphia, 1830.

On Artificial Anus—Desault's *Works*, by Smith, vol. 1, article *Preternatural Ani*, p. 306—Travers on the *Intestines*, p. 295—Scarpa on *Hernia*, *Memoir* 4th, p. 288—Hennen's *Military Surgery*, 2d edit. p. 407—Dorsey's *Surgery*, vol. 1, p. 96—Reybard sur les *Traitement des Anus Artificiel*, 8vo.—*Account of a Case in which a new and peculiar Operation for Artificial Anus, performed, in 1809, by Philip Syng Physick, M. D., then Professor of Surgery in the University of Pennsylvania. Drawn up for publication by B. H. Coates, M. D., in North American Medical and Surgical Journal*, vol. 2, p. 269.

CHAPTER VI.

DISEASES OF THE RECTUM.

IT is but too common for students to pay particular attention to favourite subjects, and neglect others not less important. The diseases of the rectum, I have frequently perceived, are little relished; being considered not only loathsome and uninteresting, but very simple in their nature, and easily cured. Experience teaches the reverse. Many a patient has lost his life from an ill-managed fistula in ano, or from an operation upon it, unnecessarily, or improperly performed. A small portion of dissecting-room labour, (too often wasted upon the muscles,) is the proper corrective for this error.

The principal diseases of the rectum are prolapsus ani, tumours within the rectum, hemorrhoids, and fistula in ano: those less frequently met with, are imperforate anus, foreign bodies in the rectum, neuralgia and spasms of the anus, atony and injuries of the anus, blenorragia, strictures and fissures of the rectum. The latter disease, (fissure,) I have never met with, nor do I find, upon inquiry, that it is known, personally, to any other surgeon in this country. On this account, I shall not treat of it, but refer, for information on the subject, to European writers.

SECTION I.

Prolapsus Ani.

FROM habitual costiveness, straining at stool, diarrhœa, dysentery, hemorrhoids, strictures in the urethra, stone in the

bladder, drastic purgatives, irritation from ascarides, and various other causes, the lining membrane of the rectum, immediately above the internal sphincter, is sometimes inverted, and protruded to a greater or less distance beyond the verge of the anus. Infants, and very old people, are most liable to the complaint, which, if the tumour be large, recent, and accompanied by much inflammation, may terminate in gangrene, or give rise to symptoms of strangulated hernia. In general, however, this result is not to be apprehended, and the disease must be considered as rather inconvenient and troublesome than dangerous. In some cases there is reason to believe that there is an *intus-susception* of the gut itself, instead of an eversion of its lining membrane.

In other instances, the sigmoid flexure, and other portions of the colon, may be invaginated and finally protruded at the anus. Even the cæcum may undergo a similar displacement. Not unfrequently, the upper part of the rectum descends and lodges in the *pouch* of the same intestine. But these affections differ, in toto, from genuine prolapsus ani. To understand the true nature of prolapsus, it should be recollected that perpetual straining from irritation, however induced, may give rise to infiltration in the cellular tissue, beneath the villous coat, and that this congestion must have the effect, finally, of causing protrusion of the lining membrane of the gut. In chronic cases of the disease, or where unusually large protrusions have taken place, there is reason to believe that the folds of the inner coat, which line the pouch or natural sinus, above the internal sphincter, and which are uncommonly numerous and relaxed, are forced by the action of the abdominal muscles from their lurking-place, and carried in volumes beyond the verge of the anus. Several cases of the kind I have seen, and one especially during the winter of 1835, at the Alms-House Infirmary, in a man 36 years of age, named Dubois, in whom the protrusion, equal in bulk to the fist, and of a dark red colour covered with irregular ridges and furrows, not unfrequently descended five or six inches, beyond the margin of the anus.

According to Mr. Mayo, of London, not only the mucous and submucous coats of the rectum are liable to eversion, but the muscular coat also—as is proved by a preparation in the Museum of King's College, of which Mr. Mayo has furnished a drawing.

Treatment of Prolapsus Ani.

In the treatment of this disease, it is highly important to return the protruded parts as speedily as possible. This is best accomplished by placing the patient on his back, elevating the hips and shoulders, and pressing gently with the fingers, (previously oiled,) upon the tumour. Should the parts be very tender and inflamed, and offer much resistance, the efforts towards reduction must be discontinued, until full benefit has been derived from general and local blood-letting, mild purgatives, cold poultices, astringent washes, &c. To support the protrusion, after it has been reduced, and to prevent its recurrence, a piece of lint, covered with some mild ointment, should be applied to the anus, and over it a soft sponge and bandage. Rest, also, for some time in the horizontal position, will prove essential. Dr. Physick has sometimes cured prolapsus ani by confining the patient for a considerable time to a diet of rye mush and sugar. It must be obvious, however, from what has been stated, that much will depend upon the cause of the disease, as respects the prospect of a permanent cure; and that so long as many of the causes pointed out continue to operate, little advantage can be gained by any mode of treatment that may be instituted. The protruded parts, now and then, become indurated and *incapable of reduction*. Under such circumstances, it may be necessary to remove them, either with the ligature or knife. When the tumour appears to be very vascular, and is small, I should prefer removing it by the double cannula and wire, as used by Dr. Physick for hemorrhoids. But when it has long remained protruded, is disorganized, and has, apparently, very little connexion with the parts within the rectum, I should resort to the operation long ago practised by *Hey*—the removal of one or more flaps, or of the whole mass, by excision. This I have practised successfully, in several cases, without inconvenience. At other times, considerable hemorrhage has followed the operation. The young surgeon should be on his guard, therefore, and take care how he ventures to cut off a large *reducible* prolapsus of the mucous membrane; and, above all, that

he does not amputate an invaginated *colon* or *cæcum*, under the idea that he is merely removing folds of the lining membrane of the rectum.

An ingenious operation, first suggested and practised by Dupuytren, (and for which, in a former edition of this work, I have failed to award him the credit he deserves,) is better calculated, so far as I can determine, by a few trials of it, to effect a cure of prolapsus ani than any other ever invented. Instead of cutting away the mucous membrane of the gut, Dupuytren seizes with a pair of small forceps a greater or less number of the *radiating folds* of skin which naturally surround the outside of the anus, and with a pair of curved scissors, cutting from without inwards, removes them. When the prolapsus is large, these folds should be pinched up in two or three different places and cut off: but in small tumours of the kind, such as are generally met with in children, the removal of two or three folds at a single spot will commonly prove sufficient. Occasionally, it is necessary to prolong the incision into the rectum as far as the point where the radiating folds are fused insensibly into the mucous membrane of the rectum. The object of this operation, as will be understood immediately, is to contract (through the medium of a *cicatrix*, which must necessarily form when the wound made by the scissors has healed up,) the margin of the anus, or to diminish the size of that opening, and thereby to afford a support to the loose folds of the mucous membrane of the gut they were destitute of in the relaxed condition of the parts, as usually found in cases of prolapsus. In an obstinate case of this disease, in a girl three years old at the Alms-House Infirmary, during the winter of 1835, (and where the protrusion, the size of an egg, had been partially removed, previously, by dissecting off ribands of the lining membrane with a view of exciting the adhesive inflammation,) I succeeded in effecting a perfect cure of the prolapsus, merely by cutting away, in two places, the converging folds of skin, in the manner described.

In the case of Dubois, referred to above, I performed a similar operation; but the long standing of the disease, and the extraordinary bulk of the tumour, prevented me from succeeding.

However, as regards both the operations of Hey and Dupuytren, it should be remarked, that, if carried too far, there may be a possibility of producing such a contraction of the parts,

within the rectum and at the anus, as to interfere, ever afterwards, with the evacuation of the fæces. Cases of the kind have been reported by Chesselden, and by the old anatomist Keil, where the patients could never procure a stool without the assistance of a clyster, and, even with that alternative, suffered immensely.

It must not be supposed, from the remarks already made, that an operation will be required, necessarily, for the cure of prolapsus ani. On the contrary, many cases occur, in children especially, where by early attention to the disease, the use of saturnine and astringent injections, keeping the bowels in a soluble state, and, above all, by obliging the child to evacuate the fæces whilst in a *standing position*, perfect cures will be effected in a few weeks or months.

Perforated ivory balls, gum elastic and other pessaries, the craw of a turkey, lint plugs, sponges, steel trusses, and other contrivances, have been resorted to for sustaining the prolapsed parts, or for effecting radical cures through the medium of adhesive inflammation, but generally without effect. As some patients, however, have derived benefit, undoubtedly, from them, they should in certain cases be tried. But if, upon trial, they are found, as is generally the case, to act as *suppositories*, they will do more harm than good, and should be abandoned.

On Prolapsus Ani, consult *Monro's Essay on Procidentia Ani*, in *Edinburgh Physical and Literary Essays*, vol. 2d, p. 353—*Chesselden's Anatomy of the Human Body*, 1792—*Chevalier on Relaxed Rectum*, in *Medico-Chirurgical Transactions*, vol. 10, p. 401, 1819—*Sabatier, Memoires sur les Anus contre Nature*, in *Memoires de la Academie Royale de Chirurgie*, tom. 15, 12mo edit.—*Hey's Practical Observations in Surgery*, p. 438. London, 1814—*A Treatise on the Diseases of the Urethra, Vesica Urinaria, Prostate, and Rectum*, by C. Bell, with Notes, by J. Shaw, p. 324. London, 1820—*Dupuytren on Prolapsus of the Rectum*, in *Clinical Lectures on Surgery at Hotel Dieu, &c.*, translated by Doane, p. 99—*Observations on Injuries and Diseases of the Rectum*, by Herbert Mayo, p. 28. London, 1833—*American Cyclopædia of Practical Medicine and Surgery*, Edited by Isaac Hays, M. D., Part 6, p. 96. Philadelphia, 1835—*Colles' Surgical Anatomy*, p. 139.

SECTION II.

Tumours within the Rectum.

SARCOMATOUS and other tumours occasionally sprout from the surface of the lining membrane of the rectum, and according to their bulk and figure, excite more or less irritation, diarrhœa, &c. Sometimes they originate between the coats of the intestine. Mr. John Bell* speaks of enormous tumours of the rectum, soft, woolly, lubricous, of a shining red colour, involving the whole circle of the anus, extending beyond it many inches, and retiring deeply within the cavity of the gut. Such I have not seen.

*Treatment of Tumours within the Rectum.*

When the tumour originates by a very narrow pedicle, and moves freely about, it may sometimes be pulled away with a pair of forceps; but when its base is broad, the ligature will prove the safest and most effectual remedy. It will answer no purpose, however, merely to encircle the swelling with a single cord. Many years ago, I was consulted by a gentleman of Maryland, on account of a fleshy excrescence, about the size of an egg, which arose from the walls of the rectum an inch and a half above the sphincter ani. A surgeon of eminence had undertaken to re-

* Principles of Surgery, vol. iii. p. 188.

move the tumour by a single ligature; but, unable to noose the base of the swelling, its anterior part only was destroyed, and the operation proved fruitless. I determined to proceed in a different way. Directing the patient to sit for half an hour over a tub of warm water, and by straining, to force the tumour as far as possible below the sphincter, I passed a crooked needle, armed with two ligatures, through its substance, as near as possible to the coats of the bowel, and tied one on each side. In four or five days the diseased mass sloughed away, and a perfect cure followed.

By similar means I have removed, repeatedly, since, both large and small tumours, and almost invariably with success. The knife, upon such occasions, should never, I think, be employed, on account of the hemorrhage which would be almost certain to follow the extirpation of a vascular tumour within the walls of the rectum, and the difficulty which the surgeon would experience, necessarily, in securing the vessels in that situation. The advantage possessed by the double, over the single ligature, is, that two portions of the tumour being embraced, at the same moment, the sloughing will be accomplished with greater rapidity than if the whole mass were encircled. Besides, the ligatures having been passed through the substance of the tumour, cannot be detached until the tumour is removed.

On Tumours of the Rectum, consult *C. Bell's Operative Surgery*, vol. 1st—*J. Bell's Principles of Surgery*, vol. 3d, p. 191—*A Treatise on the Diseases of the Urethra, Vesica Urinaria, Prostate and Rectum*, by C. Bell, p. 323.

SECTION III.

Hemorrhoids.

HEMORRHAGE, occasional, or periodical, from the verge of the anus, or from the cavity of the rectum, is very common among persons of indolent and sedentary lives, and of full habits of body. Costiveness, pregnancy, severe exercise on horse-back, and many other causes may give rise to the complaint. It is still a disputed point whether the blood proceeds from varicose distention of the hemorrhoidal veins, or is poured into cysts formed of the cellular membrane, between the coats of the bowel, or beneath the integuments of the anus. Both opinions are, I am sure, well founded. In by far, however, the greater number of instances, hemorrhoidal tumours are formed by enlargement of the veins of the rectum. This varicose condition of the veins is brought about, there is reason to believe, by repeated straining at stool, during which the sphincters are of necessity relaxed, so that a column of blood, unsupported by valves, and driven by the action of the abdominal muscles against the mesenteric veins, dilates, and, not unfrequently, bursts them. In the course of time, from repeated attacks of inflammation, coagulable lymph is thrown around the distended veins, their coats are thickened, and fleshy tumours created, which enclose the veins in their substance, and either diminish, or obliterate, altogether, their cavities. But more or less of the cavity of the vein generally remains, concealed within the tumour, and often this cavity is much larger than the original vessel, and, if opened, will shed blood profusely. Hemorrhoidal tumours, so long as they remain within the cavity of the rectum, are mostly free from pain; when they protrude, however, beyond the anus, and are compressed by its sphincter, they frequently become ex-

quisitely sensible, and greatly enlarged. The margin of the anus is sometimes surrounded by a cluster of tumours of a dark red or purple colour; at other times only a single protuberance is visible.

Treatment of Hemorrhoids.

The remedies for this disease are either palliative or radical. Among the former may be enumerated leeches, cold astringent washes, astringent ointments, rest in the horizontal position, mild laxatives, general blood-letting. In several instances I have derived great benefit from a poultice made of the pulp of the green persimmon, and also from a decoction of the bark of the persimmon tree. The extracts of stramonium, and belladonna, I have used for twenty years, and have found, in particular cases, extremely soothing, and useful. Internally administered, there is nothing better than the old remedy extolled by Benjamin Bell—the balsam copaibæ.

When hemorrhoids become large and troublesome, or irreducible, an operation will be required. The knife, or ligature, will prove equally successful. The use of the former, however, is sometimes followed by profuse hemorrhage, violent inflammation, and even death. Three instances of fatal termination are related by Sir Astley Cooper. The first was that of a lady, who died in a week from peritoneal inflammation, induced by the removal of a single pile by the scissors; the second that of a gentleman who died from hemorrhage on the second day after the operation. In the third case, Sir Astley removed a large hemorrhoid by the scissors from the anus of a nobleman. “In about ten minutes after the operation, he said, ‘I must relieve my bowels,’ and he rose from his bed and discharged into the close stool what he thought to be fæces, but which proved to be blood. In twenty minutes he had the same sensation and evacuated more blood than before, in about the same lapse of time: he again rose, and soon became very faint from the free

hemorrhage. I therefore opened the rectum with a speculum, and saw an artery throwing out its blood with freedom. I therefore requested him to force down the intestine as much as he could, and raising the orifice of the bleeding vessel with a tenaculum, secured it in a ligature and also compressed the artery with a piece of sponge. His lordship bled no more. On the following day he was low, his pulse very quick, and he had a shivering; on the next day he complained of pain in his abdomen; he had sickness and tenderness upon pressure, and in four days he died."

Similar cases have been reported by other writers, both in this country and in Europe. When we recollect, indeed, that piles consist, in nine cases out of ten, of dilated veins, and that there are no valves from the anus to the liver, so that the whole column of blood must press upon the rectum, it is only surprising that surgeons, knowing these facts, should undertake to operate, as often as they do, with the knife, and scissors, and that a much greater number of accidents have not been met with. The latter circumstance can only be accounted for by the fact that tumours, which were originally varicose veins, have become obliterated by adhesive inflammation, or been converted into disorganized masses of cellular membrane, veins and skin, and that when, under these circumstances, clipped off by a cutting instrument, have shed little or no blood. Such being the case, it is important to draw a distinction between a cluster of dilated veins, within the sphincter, or projecting beyond the margin of the anus, and those lifeless indurated growths, which so often occupy the same situations. The latter may be safely cut away; but the former never can, without imminent risk of the patient's life.

It is true that whilst most eminent surgeons are adverse to the removal of *venous* hemorrhoids by the *knife*, one or two others, equally eminent, have advocated the practice when conjoined with collateral means. Thus, Dupuytren, the magnus Apollo of French surgery, has boldly recommended and practised not only the removal of piles by cutting instruments, but the application of the actual cautery, immediately afterwards, for stemming the torrents of blood. His own mouth has sufficiently condemned, we think, both the operator, and the operation. "I have seen you," says he in his Lectures, "shudder more than

once at the sight of the red hot iron, and at the cloud of smoke which arises from the cauterized part: you may judge what an impression such a preparation would produce on the friends and relations of the patient, who are not, like you, accustomed to such scenes." Again: "It is also to avoid this disastrous occurrence—*hemorrhage*—that we make it a rule not to apply the dressings for some hours after the operation, because it is to be feared that the dressings would only hinder the blood from flowing out, and thus cause it to flow back into the superior intestines." What we apprehended happened the next day: an internal hemorrhage manifested itself; the pupil of the ward was not mistaken. He gave him (speaking of a particular patient,) an enema, which brought away a great quantity of blood; a second enema brought a considerable clot. He then made the patient strain first to expel any blood that might remain, and, secondly, to cause relaxation of the sphincter, and exhibit the surface of the divided arteries; then he applied to the bleeding parts two red hot iron instruments. The quantity of blood lost in this operation has been estimated to be three, four, and five pounds. It flows into the descending, the transverse, and the ascending colon, and as far as the cæcum, but never beyond this. From the effects of the cauterization he experienced a retention of urine, and it was necessary to use the catheter. After the evacuation of a great quantity of urine, he felt violent pain, which did not cease until the organ returned to its usual state." Again: a very wealthy banker is attended by Dupuytren, who, with a pair of large forceps, pulls down the hemorrhoids and cuts them off. "At the end of a quarter of an hour, the patient became pale, fell into a state of extreme weakness, the pulse small and hard, a cold perspiration covered his body, and he felt a sensation of heat in the abdomen, continually ascending. The Professor immediately recommended the patient to make expulsatory efforts, and a great quantity of scarcely coagulated blood was discharged. Cold injections were useless; the hemorrhage was not stopped: then a pig's bladder, stuffed with lint, was introduced. This succeeded completely: but it was not without great difficulty it could be kept in its place; involuntary expulsatory efforts tended incessantly to displace it, and actually did so several times. This hemorrhage weakened the patient very much, and would undoubtedly have been fatal, if it had not been arrested so

promptly." The banker's brother had a similar disease, is treated in a similar manner, and would certainly have died, but for the presence of mind of another brother, who, in the absence of the surgeon, introduces the pig's bladder, and stops the blood. "But the loss of blood was so great that the patient was a *long time before he recovered*." In another instance, a Scotchman, an officer of dragoons, is subjected to excision. "There were three tumours not very voluminous, and as there was but a trifling effusion of blood, M. Dupuytren thought that cauterization might be dispensed with. About five hours after the excision, all the characteristic symptoms of hemorrhage in the rectum were manifested: *anxiety, rigors, inclination to vomit, cold perspiration, sinking of the pulse, convulsive contraction of the limbs, inexplicable agony, vertigo, syncope, tremors* increasing, the patient went to stool, and the expulsion of a considerable quantity of partly coagulated blood, gave him visible relief. At the expiration of about an hour the symptoms returned with increasing intensity: they produced complete *collapse*. The patient requested a notary should be sent for, and hastened to arrange his affairs, preferring death, which he thought inevitable, to cauterization. With the aid of a speculum, the place from whence the blood flowed was easily found, and the effusion stopped by the application of a bent *cauterie en haricot* heated to a white heat; a wick was kept in the rectum, and in a few days the patient was perfectly cured." Other cases are reported, in favour of *excision*, and the *cautery*; but the details, correspond so exactly with each other, that it is superfluous to state them. Besides, the disastrous effects of *excision*, and the *cautery*, already pointed out, it should be mentioned, (and the fact is admitted by Dupuytren,) that contraction of the anus, to such a degree as greatly to interfere with the patient having a stool, not unfrequently follows. Under all these circumstances, may we not exclaim, Cui bono? Why subject an unfortunate individual to such torture? Why give rise to hemorrhage, merely for the sake, apparently, of showing our dexterity in stopping it?

The *ligature*, then, in our estimation, is the only safe operation, for the generality of hemorrhoidal tumours. As practised by the older surgeons, and by most of the moderns, there can be no doubt that inconvenience, and sometimes very severe pain, and other unpleasant symptoms, follow its application; but

that any thing like the consequence spoken of by old Petit, and handed down from one generation to another,—symptoms of strangulated hernia, and death—ever follow from performing the operation, as it ought to be performed, or even when performed in the most bungling manner, I am very far from believing.

To Dr. Physick we are indebted for the best mode of performing this operation. A double cannula of the ordinary form, but only *two inches long*, is selected, and “a piece of tough, flexible, pure iron wire, one twenty-fourth part of an inch, or rather less, in diameter, having firmness enough to allow of its being pushed backwards and forwards in the cannula,” is passed through both barrels of that instrument, and whilst one end is secured at the wing of the cannula, the other remains loose. A loop being formed adapted to the size of the hemorrhoid, is passed around it, and then drawn as *firmly as possible*, by pulling upon the extremity of the wire projecting from the lower end of the cannula with a pair of flat pliers, and then securing its end to the opposite wing. In twenty-four hours, or sometimes twelve, the wire is loosened from the wing of the instrument, straightened by the pliers and cautiously pushed back, and its loop disengaged from the tumour, which by that time is commonly found black, shrivelled, and free from pain. A poultice is then applied, and in a few days the tumour is entirely separated. The *peculiarity*, it will be perceived, of the above operation, consists in the *unusual firmness* with which the wire is drawn, and its being removed in a few hours, instead of being suffered to remain for *several days*. “No one can properly appreciate,” says Dr. Physick, “the advantages resulting from the above method of removing hemorrhoidal tumours, who has not seen them treated, by allowing the ligature to remain during the separation of the part. Under that mode of operating, the patient is never at ease during the whole time; the discharge of the *fæces* is often excruciating, even moving in bed is dreaded, and in the last case in which I performed the operation in that manner, the convulsive twitchings of the lower extremities, which were induced, became so frequent and violent, that I was uneasy, through an apprehension of tetanus being the consequence. It seems to me probable, that one reason of the difference between the effect of the wire, and a com-

mon ligature may be, that, however firmly the waxed ligature may be drawn and tied on the base of the tumour, before a second knot can be tied to secure the first, the elasticity of the parts compressed opens the first knot a little, and of course the exclusion of blood, and nervous influence is not so complete as when the wire is used, which can be fastened on the arm of the instrument at the time when it is drawn round the swelling as tightly as possible. The pinch given by the wire is soon destructive, and any degree of restoration is rendered impossible.

“It might be supposed, if a thread were used, it could be cut off after a short time; but the swelling comes on so speedily, the parts retract so much within the anus, and are so extremely tender to the touch, that it is difficult to find the noose: when found, the operation of dividing it either with knife or scissors, is productive of so much pain, that I have known some patients refuse to submit to it. The removal of the wire occasions no pain. It may be proper to mention, that when the tumour happens to be attached to the inside of the anus, anteriorly, some difficulty in voiding urine is often complained of; but this symptom, always, in my patients, has subsided immediately after the removal of the wire. “Where,” Dr. Physick further remarks, “hemorrhoidal tumours are only protruded in the act of evacuating the fæces, then their *excision* would be attended with great risk of hemorrhage. This some have denied, but having twice witnessed the fact to a *very alarming extent*, I wish, on all such occasions, to guard against it.”

For many years I have practised the operation just described, both on small, and large hemorrhoidal tumours, and in a great many instances, and can positively declare, that, although I have often known very sharp, and severe pain to follow the tightening of the ligature in some, that in others very little complaint has been made, and that in all very perfect and speedy cures have been accomplished. In proof of this, I shall relate a case which, I think, will be acknowledged to be equal in extent to any reported by Dupuytren.

Mr. B., a respectable merchant of Danville, on the Susquehannah, had suffered for fifteen years with internal hemorrhoids. His constitution was naturally very fine and vigorous, but from repeated hemorrhages from the rectum, he had become ema-

ciated, and so debilitated, and suffered so much pain from the protrusion of the tumours, that he could scarcely attend to his business, and life had almost become a burden to him. When I saw him, his skin was of a pale yellowish hue and his whole aspect cadaverous. After resting a few days, to recover from the fatigue of his journey, he was directed to sit for half an hour over a bucket of warm water, and force down gradually the tumours. They came out, and as they descended became ravelled up into rolls, each as thick as the thumb, covered with blood and sero-purulent matter. There were two or three masses which completely surrounded the verge of the anus, but which presented, when superficially examined, an irregular, tuberculated, dark purple, very vascular, highly sensitive tumour, as large as the fist. The patient was put to bed, a gentle aperient ordered, and the next day, immediately after the tumours, (by straining over warm water) had been forced down, was laid on his side over the edge of a bed, and the largest and most painful mass selected, included in the iron wire ligature, as near its base as possible, and the wire drawn with all the force I was master of. The pain, for an instant, was agonizing; but soon subsided—owing to the death of the tumour, thus so suddenly brought about. In fifteen or twenty hours, the wire was removed, and a warm poultice applied to the parts. In four days the remains of the tumour were completely separated, and the patient returned home in a fortnight, perfectly cured of the protrusion and of the hemorrhagies, and in a few months recovered his health. Seven or eight years have now elapsed since the operation; and I have never heard of his having had a return of this complaint. It may be asked what became of the remaining tumours. They were obliterated, by the supervention of the adhesive inflammation—a fact very important to be known, and an occurrence by no means uncommon. Aware of this, the surgeon should always make it a rule never to include *numerous* hemorrhoids, or a very *large* mass, in a ligature, at a single operation, (in order to guard against violent symptoms,) but take his chance of curing all by one operation, and of repeating it, subsequently, should the remaining tumour require it. A case, in some respects similar to that of Mr. B., I operated on, in presence of Dr. Physick, five years ago, and with the same happy result. The patient, Mr. W., long before and since the operation, a

most valuable officer of the government at Washington, had determined to abandon his office, unless he could have obtained relief.

I need hardly remark, that I have operated in a great many instances for small hemorrhoidal tumours, by the mode already described, and peculiar to Dr. Physick, and invariably with success, and I am very sure that no surgeon can properly appreciate the value of the ligature unless he use it according to the principles pointed out, and unless he fulfil the most important indication—to draw the wire with very great firmness.

On Hemorrhoids, consult *Abernethy, on Hemorrhoidal Diseases, in Surgical Works, vol. 2d*—*Earle on Hemorrhoidal Excrescences, 1807*—*Kirby on the Treatment of Hemorrhoidal Excrescence*—*Ware on the Treatment of Hemorrhoids*—*A Practical Treatise on Hemorrhoids, &c., by George Calvert*—*The double Cannula and Wire recommended in the Operation of Extirpating Scirrhus Tonsils, and Hemorrhoidal Tumours, by Philip Syng Physick, M. D., in Philadelphia Journal of Medical and Physical Sciences, vol. 1, p. 17, 1820*—*Excision of Hemorrhoidal Tumours, in Clinical Lectures on Surgery, by Dupuytren, translated by Doane, p. 105, Phil. 1833*—*Observations on Injuries and Diseases of the Rectum, by Herbert Mayo, London, 1833, p. 53.*

SECTION IV.

Fistula in Ano.

WHEN an abscess forms in the cellular membrane surrounding the rectum, or about the verge of the anus, and leaves, after its contents are discharged, one or more small openings communicating with its cavity, the disease is denominated fistula in ano. Other appellations have also been invented, expressive of the particular situation of the fistulous orifice, and the extent of the disease. If the fistula opens upon the surface of the integuments, it is called an *incomplete* fistula; if it communicates with the rectum, and not with the integuments, an *internal* fistula; and when there is an opening in the gut and another through the skin, a *complete* fistula.

The formation of a fistula in ano is often denoted by rigors, a painful swelling about the ischium or perineum, difficulty of passing urine, and by irritation of the rectum and neck of the bladder. During the progress of the disease, the patient, in many instances, suffers immensely; at other times, the abscess forms and breaks almost without the patient being aware of its existence. Generally, the abscess communicates with the integuments by a single opening; occasionally, three or four are met with; and I once attended a case of long standing, in which there were no less than fifteen. In healthy constitutions the abscess does not differ from that of the common phlegmon, met with in other parts of the cellular tissue. In consumptive and scrofulous patients, however, the disease often assumes a different shape. The surface of the integuments is covered with an erysipelatous inflammation, the fever, sickness, and pain are very considerable, the matter is discharged in small quantity, and from a sloughy, ill-conditioned opening, or from a ragged unhealthy

surface. The origin of fistula in ano cannot be always satisfactorily traced. Sometimes it arises from irritation about the rectum, from local injury, from the lodgement of undissolved articles of food taken into the stomach, and passed through the intestines as far as the rectum, such as the bones of fish or fowls. Severe and long-continued exercise, on rough-going horses, I have sometimes known to lay the foundation of the complaint. Hemorrhoids, there is reason to believe, often contribute to the disease. The same may be said of severe colds and coughs.

Treatment of Fistula in Ano.

An opinion very generally prevails that every fistula in ano requires an operation. There cannot be a greater mistake. So far from it, almost every sinus, I am inclined to think, in a patient tolerably healthy, might be healed, if attended to in the commencement, and judiciously managed. Nothing will contribute more to this end than absolute rest, simple dressings, moderate diet, and mild laxatives. I have known a fistula, (protracted and kept open for months while the patient walked about,) healed in a week by perfect quietude, and the horizontal position.

It frequently happens, however, that the surgeon is not called until the disease is firmly established, and an operation urgently demanded. But, before he undertakes it, the operator would do well to sooth the parts, and reduce the inflammation and callosity about the sinus by emollient poultices, and after the irritation has subsided, gradually enlarge the fistulous orifice by bougies, (if necessary,) before an examination with the probe is entered upon. If these precautions are neglected, and the fistula probed at once, the patient will suffer, as I have often witnessed, immensely, and, indeed, will experience infinitely greater pain than from the operation itself. It will still remain to inquire concerning the patient's general health. If consumptive, the operation can answer, generally, no good purpose: on

the contrary, it will aggravate, if the fistula should be healed, all the pectoral symptoms.

When determined upon, the operation may be performed by a common probe-pointed bistoury, by the sheathed bistoury of Dr. Physick, or by the knife of Cruikshank. The objection to the *probe* bistoury is, that it will sometimes be necessary, when there is no opening between the gut and sinus, to *make* one. For this purpose, an instrument with a sharp point will be required. Dr. Physick's instrument was constructed with this view, and possesses the additional advantage, from being covered by a silver sheath, blunt on its edges, of not cutting the tract of the sinus whilst passing along, until the operator desires so to do. Cruikshank's bistoury is constructed with a moveable stilet that can be pushed forward or retracted at pleasure, the point of which is intended to pierce the gut, and then to be withdrawn, that the surgeon's finger may rest on the blunt extremity of the knife.

Previous to the operation, the rectum is emptied by a clyster, and the buttocks being turned towards the light, are held asunder by assistants, while the patient stoops forward and rests his body and arms upon a table. The surgeon introduces a forefinger, oiled, into the rectum, passes the probe into the sinus, examines carefully its situation and extent, and having satisfied himself thoroughly in this respect, carries the sheathed bistoury, (for example,) as high as the naked outer surface of the intestine, then disengages the sheath from the bistoury, and removes it from the sinus. The point of the bistoury is next pushed through the gut, and made to rest on the finger within the rectum. Both the finger and knife are next withdrawn, the latter dividing in its passage downwards the whole tract of the sinus, the intestine, sphincter ani muscle, and integuments, and leaving a chasm of considerable extent. A dossil of lint should be next introduced between the lips of the wound, and the patient put to bed. The cure is afterwards completed by mild dressings. When there is an opening in the gut and another at the margin of the anus, or on the buttock, with an intermediate communication by a sinus, constituting *complete* fistula, no other instrument than the common probe-pointed bistoury will be required for the operation.

In performing the operation for fistula in ano, simple as it is

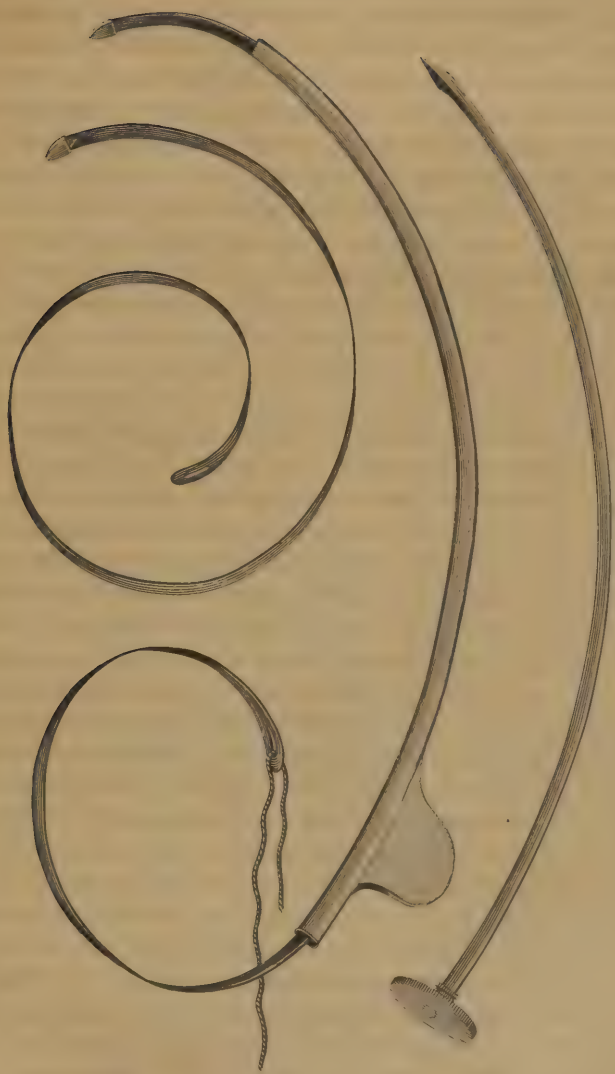
considered, the operator must remember, that if he prolongs his incision too far upwards from an over anxiety to trace every ramification of the sinus, (a very unnecessary piece of work,) he may wound the peritoneum, lay open the cavity of the abdomen, and also divide the internal hemorrhoidal artery.

The *ligature* is frequently employed, instead of the knife, for the cure of fistula in ano. As it requires, however, a much longer time to effect its purpose, and is, withal, sometimes painful and inconvenient, there are many patients unwilling to submit to the operation. But cases present themselves now and then, in which the knife could not be employed without risk of hemorrhage, or in which from the number and depth of the sinuses, it would be impossible to trace them, or if traced, difficulty would afterwards be experienced in making them heal from the bottom or in preventing the formation of new sinuses. Under these, and some other circumstances, it has been customary, particularly among the French, from time immemorial, to resort to the ligature. The material of which it is made, as well as the instruments for conveying it, have varied exceedingly in different ages. Hippocrates used a linen thread wound upon a horse-hair, others employed silver or iron wire, and many preferred leaden wire to any other kind of ligature. Some conveyed the ligature by means of a silver probe, others by a canula. Forceps for seizing the wire within the gut, and stilets for making an opening into the gut for the transmission of the ligature, have also been used. But, in many instances, it will only be necessary, when this operation is determined on, to pursue the following simple plan, one which has been practised for a great many years by Dr. Physick, and which experience has taught him to be almost always successful. A common pocket case probe, of the same thickness throughout, is slightly ragged at one end with a knife or file, and a piece of braid secured to it by thread, in the same way that the line is fastened to a fish-hook, is introduced into the fistulous orifice and conveyed along the sinus into the gut. The probe is next bent upon a finger, (previously passed into the rectum,) and brought out along with the ligature at the anus. The latter is then removed from the probe and its ends *loosely* tied. After the lapse of a few days the ligature is moderately tightened, and occasionally afterwards, (once a week, for example,) the constriction is repeated and increased,

until the parts within its embrace are completely destroyed, and the cord, *sua sponte*, detached. The small ulcer left soon heals up. Sometimes the ligature comes away in four or five weeks; at other times, eight or ten months elapse before the loop separates. In the mean time, however, the patient is generally permitted to walk about and attend to his business. In cases where no communication exists between the rectum and fistula, Dr. Physick has been in the habit of making one, by means of a sharp-pointed sheathed knife, previously to the introduction of the probe and ligature.

In peculiarly *irritable* patients, however, I have found it very difficult to carry the eyed-probe and ligature through the orifice in the gut without producing excessive pain in the act of *bending* the probe within the rectum, and which must always be done before it can be brought out at the anus. To obviate this difficulty, I invented, four years ago, the following instrument, which I have employed ever since, upon all occasions, where I have thought it necessary to use the ligature in preference to the knife, both in hospital and in private practice, and with the greatest success and least possible inconvenience to the patient. A silver cannula, moderately curved, about five inches long, the eighth of an inch wide in its longest, and the sixteenth of an inch in its shortest diameter, is intended to convey a narrow watch-spring, ten inches long, having at the extremity next the handle of the cannula an eye, and at the other a small bulbous silver point. An additional spring, differing only from the first in the silver end being small enough to pass along with the spring through the cannula, and intended for *incomplete* fistula, accompanies the instrument. A steel stilet, which fills up and traverses the cannula, and projects in the form of a small lancet, just beyond the extremity, completes the contrivance. *See Plate 3.*

If it be intended to operate on a case of *incomplete* fistula—that in which there is no opening in the gut—the cannula, armed with the stilet, and its point retracted, is entered at the fistulous orifice, conveyed carefully along the sinus until that portion of the side of the rectum is reached where it is intended to make the perforation. The stilet is then pushed through the walls of the gut, and is felt within by the finger, previously introduced into the rectum. Having withdrawn



the stilet, the spring with the flattened silver end, armed with very narrow braid, is conveyed through the cannula, and, guided by the finger in the rectum, brought out at the anus along with the ligature, which is then separated from the eye of the spring, and its ends loosely tied. In cases of *complete* fistula, the *stilet* will not be required, and the spring, with the bulbous end, previously placed in the cannula, and armed, as already described, with braid, may be employed. In either case, it must be obvious that the pressure which gives the patient so much pain when the probe is used, is taken off the fistulous *orifice* and borne by the *cannula*; and, besides, that the spring has a natural tendency, by forming a curve as it is pushed onwards, to avoid pressure, and to reach the anus with the greatest facility.

The *ligature* is often adapted to those cases in which a fistula follows, or is conjoined with phthisis pulmonalis. Under an impression that the pulmonary affection is dependant upon, or aggravated by the fistula, many patients are extremely anxious to have an operation. I have invariably refused to employ the knife upon such occasions, but have sometimes gratified them by operating with the ligature, which, by being worn for months together, is sometimes so far serviceable as to prevent the formation of other abscesses in the neighbourhood of the rectum, and by keeping up a steady drain throughout a single track, to relieve the cough, and other constitutional symptoms. The worst case of fistula in ano I ever saw, I attended, along with Dr. Physick, about five years ago,—that of a Mr. W. from the neighbourhood of Lynchburg, Virginia. The patient's whole family had been carried off by phthisis, and several of them had also laboured under fistula in ano. In Mr. W., the only remaining one of his race, there were strong premonitory symptoms of consumption, and for months he had suffered from profuse discharges of sanious, gleety, offensive matter from the rectum, all the parts about which I found indurated, covered with sinuses, and fistulous openings, with extensive ulcerations within the gut, destruction of all its coats in particular spots, and the whole rectum more or less insulated by the destruction of the surrounding cellular membrane, so that it might have been said to have floated loosely in a large bag of matter. I trimmed away many of the loose-hanging por-

tions of the rectum and disorganized cellular tissue, and endeavoured to reach by the finger and by probes the bottom of the sinuses; but found it impossible, owing to their great depth. In consultation, it was determined that there was every probability of the patient sinking under his disease, and that all that could be done for his relief would be to introduce a large cord high up the gut, and let it remain for several months. This was accordingly done by Dr. Physick, and the patient returned home. The seton, thus left, had the effect of consolidating, through the medium of adhesive inflammation, all the loose parts, and, finally, contrary to our expectations, the external fistulous openings were obliterated, the sinuses healed up, and the patient now enjoys, comparatively, good health.

When the *knife* is employed for the cure of fistula in ano, it effects its purpose by promoting the granulating process, by first dividing the *sinus*, which, so long as it remained lined by a secreting membrane, would never have been obliterated, and lastly, by dividing the *sphincters* of the gut, thereby rendering them quiescent, and preventing that incessant motion about the anus, so well calculated to interfere with and to break up the granulations as soon as they are formed. *Rest*, then, so essential in the treatment of many other diseases, is peculiarly so in fistula in ano. Though the sphincters unite very readily, in most cases, after the operation by the knife, it sometimes happens that they remain separated, a deep fissure is left, and the patient cannot retain his *fæces* as perfectly as he had been accustomed to. It is extremely difficult, under these circumstances, to restore the use of the parts. In obstinate cases of the kind, I should think the surgeon justified in cutting away the edges of the chasm, as in hare-lip, and endeavouring to unite them by suture.

On Fistula in Ano, consult *Desault's Works*, by Smith, vol. 1, p. 330—*Pott's Works*, by Earle, vol. 3, p. 45—*A Treatise on the Diseases of the Uræthra, Vesica Urinaria, Prostate, and Rectum*, by Charles Bell, with Notes, &c. by John Shaw, Surgeon; Demonstrator of Anatomy, in the School of Great Windmill Street, London, 1820. 8vo. page 297—*Copeland's Observations on some of the Principal Diseases of the Rectum and Anus*, Philadelphia, 1811—*Practical Observations on the Symptoms, Discrimination, and Treatment of some of the most Common Diseases of the Lower Intestines and Anus*, by John Howship. London, 1820—*Observations on Injuries and Diseases of the Rectum*, by Herbert Mayo, p. 28. London, 1833—*Sir Astley Cooper's Lectures*, by Tyrrell, vol. 2d, p. 336.

SECTION V.

Encysted Rectum.

WITHIN the cavity of the rectum, between the internal and external sphincters, commencing at the margin of the former, are, naturally situated, a number of small sacs, or pockets, the orifices of which look upwards, while the bodies of the sacs descend towards the anus, perpendicularly, are about a quarter of an inch in length, and have a cul de sac termination. The number of these minute pockets is in proportion to the number of grooves, situated between the columns of the rectum, and each groove terminates in its corresponding pocket. In general, from seven to thirteen sacs are found, all of which are covered and lined, by the mucous membrane of the gut. These sacs are filled, there is reason to believe, with *mucus* (poured out by the numerous adjoining follicles) which is pressed out of their cavities during the passage of the fæces, and serves, probably, to lubricate that portion of the anus covered by cuticle. According to Ribes, such sacs had been noticed by Ruysch, Morgagni, and Glisson, as being accidentally met with in the rectum upon certain occasions. Ribes himself was unable to find them, although he had made numerous dissections for the purpose, during the period of twenty-five years. Subsequently, he was more fortunate, and was able to find in one subject three, and, in another, four of these *lacunæ*, but which he has not described with perfect accuracy. It remained for Dr. Horner to establish the fact, by numerous and most satisfactory examinations, that (what the anatomists, referred to, considered as accidental occurrences) these sacs exist invariably, and form a portion of the natural apparatus of the rectum.

So far back as the year 1792, Dr. Physick met with a peculiar

disease of the rectum, which had never been described or noticed by writers. It consisted of one or more sacs, of different dimensions, which, by bending a probe upon itself, introducing it into the rectum, and hooking it into the mouth of the sac, could be drawn down and made to appear on the outside of the anus. From that period he was accustomed to speak of this case (and others, which he subsequently met with) in his surgical lectures in the University of Pennsylvania. From 1792 to the present time, 1835, his experience in the complaint has been very considerable, a great number of cases having occurred in his own practice, and in the practice of others by whom he has been consulted.

From what has been said, it will be readily inferred that this disease, to which the attention of Dr. Physick was originally drawn, must consist in an expansion, or dilatation, of the small *natural sacs* of the rectum, described in the commencement of this section. Such, we have every reason to believe, to be the fact, though, strange as it may seem, no dissection has ever yet been made, so far as we are acquainted, calculated to *demonstrate* that the *preternatural* pouch is an actual enlargement of the *natural* one. From the circumstance, however, of small portions of *fæces*, or foreign bodies, such as seeds, &c. having being found in the dilated sacs at the time of operation, it is more than probable that these articles, by finding their way occasionally into the natural pockets, may, by irritating them, cause their expansion and elongation, and produce the disease in question. Dr. Physick, himself, seems inclined to believe that "they commence in the same manner with one of the forms of hemorrhoidal tumour. The constriction of the sphincters which embarrasses the venous circulation of the part, aided by the pressure exerted in passing different stools, frequently give rise to ecchymosis beneath the integuments. The effused blood produces no irritation of the cellular tissue in which it is placed, but forms for itself a simple inert receptacle. If the blood is neither absorbed nor discharged, but remains or becomes enlarged by successive ecchymoses, it constitutes (certain authorities to the contrary, notwithstanding,) one form of hemorrhoid. If, on the other hand, some accident, or the absorption of the integument, gives exit to the blood, after the cavity has become

accustomed to its presence, the cellular tissue shows little disposition to reunite, no obvious marks of inflammation appear, and a preternatural cavity is established. In support of this explanation, which is urged with characteristic caution, as an hypothesis, Dr. Physick states, that in the early part of his practice, he has, in several instances, operated on hemorrhoidal tumours of the same part, in which after the removal of the coagula, the part presented precisely the same aspect with the preternatural cavities, wanting only the orifice. He refers, also, to the existence of similar cavities after the discharge of ecchymoses of the scalp, such as most surgeons must have seen, particularly in children, and which often prove tedious and difficult of cure: he has also witnessed the same accident in other parts of the body. In most cases the first appearance of the cavities was preceded by troublesome piles.”*

It generally happens that patients troubled with sacculated rectum, have complained for weeks, or months, of uneasy, disagreeable, sensations, (resembling those created by the nestling of ascarides, within the gut,) or of extraordinary itching about the anus. Others complain of a sense of pressure or weight upon the extremity of the rectum. *Pain* is seldom felt until the disease has existed for some time, and even then, is not generally noticed until a short time after the passage of the fæces. It does not, however, follow *every evacuation*, and the patient may be free from it for whole days together. Sometimes it is extremely severe. For the most part there is more or less smarting shortly after each stool—owing, in all probability, to small portions of fæces finding their way into the *pouches*, and there exciting irritation. The secretion of mucus within the rectum is usually increased, but pus, except in the advanced stages of the complaint, or when inflammation has supervened, is rarely noticed. Upon the whole, it may be stated that this affection is often confounded with neuralgia of the rectum, and that, not unfrequently, even after examination, the patient's complaints have been pronounced, by practitioners, *imaginary*.

* Hay's Cycloped. of Pract. Med. and Surg. Part 6, p. 125.

Treatment of Encysted Rectum.

When the surgeon has reason to believe, from the absence of inflammation, or of free discharge of mucus and pus, from the want of spasms about the sphincters, that there is no internal, or occult fistula, in the rectum, and no neuralgic affection, and, above all, when the *symptoms* enumerated have been strongly marked, especially uneasiness and pain, a short time after stool, he will naturally suspect enlargement of the rectal pouches, and proceed accordingly.

The mere introduction of the finger into the rectum will not enable the surgeon to detect this disease. Dr. Physick, as already mentioned, takes a probe with about half an inch of its extremity bent back upon itself, and by moving it upwards and downwards, throughout that portion of the circumference of the rectum situated between the two sphincters, is able by patience to explore successfully every part of the surface of the mucous membrane. When the dilated pouches exist, the reverted extremity of the probe drops readily into them, and each cyst may be drawn down to the verge of the anus, and distinctly seen—though not without producing severe pain to the patient. That the portion drawn down is really one of the rectal pouches may be known by its transparency, for the probe shines distinctly through it—and by the exquisite pain which the bare admission of the probe into its cavity occasions. Several of the enlarged pouches often exist simultaneously; at other times, they enlarge in succession, and months may elapse before a complete cure can be accomplished. Having drawn the cyst down by the hooked probe, Dr. Physick then cuts off the whole of it, including the orifice where the probe entered, by a pair of scissors, so that its edges retract, and are soon obliterated and blended insensibly with the smooth surface of the rectum. Should other sacs exist, or form subsequently, they must be treated in a similar manner, until a radical cure is effected. In the hands of Dr. Physick, the practice has invariably proved successful, and the remark is confirmed by my own experience. So far

back as 1812, I attended the late Dr. S. of Baltimore, with this complaint. It was the first case of the kind I ever saw. The nature of the disease, in this particular case, had been previously detected by Dr. Physick, and by operating in the manner he advised, I soon effected a perfect cure. I have operated subsequently, and successfully, in numerous instances. For further observations on this subject, the reader is referred to an article by Dr. R. Coates, (drawn up under the superintendence of Dr. Physick,) in the seventh number of a recent valuable publication—the American Cyclopædia of Practical Medicine and Surgery, by Dr. Hays.

SECTION VI.

Stricture of the Rectum.

SIMPLE stricture of the rectum, like that of the œsophagus and urethra, may be either spasmodic or permanent. The former, however, is not very common, and, when it does occur, is the result, probably, of disordered action of the sphincter muscles, of the levator ani, and also, not unfrequently, of the muscles of the perinæum and of those surrounding the urethra. But the permanent, or organic stricture of the rectum, if it be not so common as some other affections of that intestine, is nevertheless, by no means rare. It may occupy any part of the rectum, but is, commonly, met with at the upper margin of the internal sphincter; and consists of a fold of the mucous membrane or coat of the gut, which in the form of a tumid ring hangs, at first loose in the bowel, but in proportion as it acquires, from repeated straining, and irritation, firmness, projects horizontally towards the centre of the rectum, to a greater or less distance, so as to resemble in some cases a septum with a hole in its middle. Sometimes there are two or three of these folds, or ridges, within a short distance of each other, which either continue separate or, in the course of time, approximate, and form an indurated tube, which diminishes the capacity of the bowel and subverts its texture. In either case, or in that of a single ridge protruded into the caliber of the gut from its walls, the effect must be a girding, or coarctation, well calculated to interfere with the passage of the fæces, or to produce wire-drawn-like stools. Hence, all patients complain of their excrement being contracted; and this, indeed, will be found to be an almost certain accompaniment of the disease, though not an infallible diagnostic, or criterion. As the stricture increases, other symptoms

are developed; there is perpetual straining or nisus, sometimes followed by mucus, sometimes by blood, either from rupture of small vessels about the rectum or from superadded piles. The bladder, also, becomes involved, and great irritation and painful micturition ensue. Eventually, the rectum becomes extremely irritable, and so exquisitely sensitive, that the patient is often afraid to attempt the expulsion of the fæces; or, if they are passed at all, it is through the medium of purgatives, enemata, or diet, calculated to keep the contents of the bowels nearly in a fluid state. If not soon relieved, great distention of the bowels, from flatus and food, takes place, followed by more urgent symptoms, and the patient dies. Not unfrequently, he has lived for years in a miserable condition, the real nature of his case unknown to himself or his attendant, and has, finally, recovered under the management of some more skilful surgeon.

Strictures of the extremity of the rectum, or, rather, coarctations of the orifice of the anus, are occasionally met with. This disease is often the result of operations, improperly performed, for hemorrhoids, prolapsus ani, fistula in ano, &c. Sometimes depositions of coagulable lymph are thrown out either on the outer or inner surfaces of the radiated folds of skin around the anus, or immediately within the termination of the rectum, where the mucous membrane and radiated folds meet. From any of these causes the opening of the anus may be so contracted as scarcely to admit the passage of a common-sized urethra bougie.



Treatment of Stricture of the Rectum.

Before attempting to overcome, by mechanical means, a stricture of the rectum, the causes of the disease should be carefully investigated, and, if possible, removed. Great attention should, in particular, be paid to the condition of the patient's stomach and bowels, through the medium of appropriate diet, gentle apc-

rients, and enemata. Repeated ablutions of the rectum by tepid and cold water alone, or holding opium or other similar articles in solution, thrown to some distance up the gut by a well contrived syringe, will pave the way for bougies and other instruments, and sometimes, without the assistance of the latter, will effect perfect cures. But soft, well made, gum elastic, or waxen, bougies are more to be relied upon, in the majority of cases, than any other instruments or modes of treatment. The surgeon should take care, however, not to promise to accomplish too speedy a cure; for if, under the impression that he has nothing to do but to break down by force the barrier opposed to him, he introduce at once a large bougie and drive it home, and follow it up shortly afterwards by another still larger, he may either destroy the patient at once by tearing the bowel, or remotely by inducing peritoneal inflammation. Very instructive cases of the kind have been published by Sir Charles Bell, Mayo, and other surgeons. The utmost gentleness, therefore, should be employed during the introduction of such instruments, and caution observed in increasing their size. The more gradual the dilatation, the less will be the irritation; and whenever it is found that the patient complains much of soreness or pain, the instrument should be diminished or withdrawn for a day or two. By prudence and discreet management, radical cures may be effected in a few months: by rash and intemperate measures, the disease will be aggravated, or the patient killed in a few weeks. The bougie acts either by dilating the stricture, gradatim, or by exciting the ulcerative process, and thereby removing, through the medium of absorption, the superfluous mass of which it consists.

It has been proposed, and by high authority, to introduce a bistoury and cut through the stricture at several points of its circumference. But I am at a loss to conceive what benefit can result from such a measure. If merely divided, will not reunion take place, almost immediately, and the ridge or septum continue as firm as ever? We cannot cut out the whole of the ridge from its base to its edge, by introducing the knife per anum, without great risk. But I have sometimes thought (should the *urgency* or *peculiarity* of the case require it,) that, by laying open the muscles of the perineum, as in the lateral operation for lithotomy, and then slitting the rectum, as is too often done

by ignorant or careless lithotomists, that the strictured portion of the gut might be completely extirpated. This, however, is a mere speculation, and as such must be received. The other operation (notching the stricture) has been performed, and successfully, it is said.

For coarctation of the *orifice* of the anus, the knife appears to be the best remedy. It must be followed up, however, by the bougie; though the cure is allowed, by all familiar with the disease, to be very difficult and uncertain.

Consult *Howship on some of the most important Diseases of the lower Intestines and Anus*, p. 1. London, 1821—*Observations on some of the principal Diseases of the Rectum and Anus, particularly Stricture of the Rectum, &c.*, by T. Copeland, p. 13. London, 1811—*A Treatise on Diseases of Urethra, Vesica Urinaria, Prostate and Rectum*, by Charles Bell. London, 1820, p. 311—*A Practical Treatise on Hemorrhoids, Strictures of the Rectum, &c.*, by Calvert. London, 1824—*Salmon's Practical Essay on Stricture of the Rectum*. London, 1828—*Two Clinical Lectures on Hernia and Strictures of the Rectum and Anus*, in *Lancet*. London, 1827—*Mayo on Injuries and Diseases of the Rectum*. London, 1833—*Hay's American Cyclopædia of Medicine and Surgery*, Part 6, 1835.

SECTION VII.

Imperforate Anus.

THIS congenital imperfection is occasionally met with, both in the human subject and among inferior animals. Sometimes it is complicated with other malformations. In my cabinet there is an interesting specimen of imperforate anus, spina bifida, and club feet; all in the same subject—a child nine months old. There are three or four varieties of imperforate anus—a mere closure by the common skin of the orifice of the rectum—a membranous septum occupying the same situation, or placed within the gut at a greater or less distance from its extremity—a cul de sac termination of the rectum—an entire occlusion of the sides of the rectum, or the conversion of the gut into a solid tumour. Along with these varieties, there is not unfrequently conjoined a communication between the rectum and vagina or between the rectum and urinary bladder, so that the fæces and urine are commingled. An uncommonly fine specimen, of the latter kind, I had an opportunity of witnessing some years ago in a thorough-bred colt, the property of the late Dr. Thornton of Washington. The animal was deficient in a tail, (its rump terminating, as in the human subject, at the os coccygis,) and the anus was completely shut up by integuments, and beneath by an apparently fleshy membrane. Along with the urine were discharged quantities of thick greenish matter, evidently of the nature of fæces. At this time the animal was a week old, sucked freely of its dam, and in other respects was perfectly healthy. Perceiving, at the natural site of the anus, a fluctuating tumour, I pushed a double-edged scalpel to the depth of an inch into the part, and immediately there was discharged about a gallon of greenish fluid, similar to that which had been

accustomed to pass from the urethra. By means of plugs and tents, the orifice was kept open, by the owner of the colt, for a few weeks; and after that time, the use of them appeared unnecessary. The communication between the rectum and bladder closed of its own accord in a very short time. The animal, I believe, is now living and in perfect health.

This statement is made for the twofold purpose—of recording an interesting fact, and of drawing the attention of students to the diseases of domestic animals, a subject in this country very much neglected and underrated. Country practitioners are often consulted, as friends, by their neighbours and patients, concerning epidemics, or local diseases, among their stock. Instead of considering their dignity insulted by such appeals to their feelings and humanity, (as too often the case,) they should furnish cheerfully all the information they possess, or prescribe in obscure and difficult cases, according to the principles that would guide them in the treatment of a human being—for between the two, as regards mere animal conformation, there is much greater correspondence than generally imagined, and similarity of texture is commonly associated with similarity of disease. Monro, Hunter, Jenner, Cline, and a host of other European physicians and surgeons, and the late distinguished Dr. Rush, in this country, have not thought it beneath them to investigate the disorders of those domestic creatures, upon which so large a share of our comforts, convenience and pleasure depends, nor to recommend such studies to their pupils.

Treatment of Imperforate Anus.

From want of timely aid, from the nature of the disease being undiscovered or misunderstood, many infants have perished that might have been saved. It is incumbent, then, upon the practitioner to investigate, speedily, the variety of the complaint the child may labour under, and to decide, promptly, upon the

treatment; for after the lapse of a few hours, meconium and other fluids may accumulate in such quantities as to produce great distention and distress, which may soon be followed by peritoneal inflammation and death. It is true, that a few cases have been reported where recoveries have taken place, although no operation has been performed until the tenth or twelfth day. In by far the greater number of instances, however, the child will not survive beyond the fourth or fifth day.

When the anus is merely covered by a common skin, or where a membranous septum is visible, or felt, a short distance within the gut, a bistoury, (wrapped throughout the greater part of its edge,) may be pushed through the skin, or through the septum, guided, in the latter case, by a finger per anum, and the obstruction removed. But where the rectum is obliterated, to any extent, by closure of its sides, or filled up by a fleshy tumour, a more delicate and difficult operation will be demanded. Either a regular dissection in the natural course of the rectum should be made until the open portion of the bowel be reached, or a trocar of large size thrust through the obstruction. Both operations have been performed, and with success in some instances; though in other cases they have failed—owing to the great extent of the obstruction, or the distance of it from the natural situation of the anus. Under such circumstances, it was proposed by Littre to cut through the parietes of the abdomen, either in the right or left groin, open an intestine and establish an artificial anus—by connecting the gut with sutures to the surrounding parts. The operation was afterwards performed, and with partial success, by Duret, a French naval surgeon. It has since been repeated by Pring, an English surgeon, in the case of a lady, in whom the rectum was closed by a scirrhus tumour. The operation was performed on the colon near its sigmoid flexure, and proved successful so far as the establishment of the artificial anus was concerned, though the patient died a few months afterwards from the scirrhus affection.

If the surgeon, in any of the varieties of imperforate anus, should succeed, by the operation described, in making his way through the obstructed rectum, he will find it necessary, in order to preserve the track or passage of suitable dimensions, to introduce plugs of lint, sponge tents, gum elastic bougies and other similar instruments, and gradually increase their size, until

the requisite degree of dilatation has been effected. This, however, will be found, in many instances, the most difficult part of the treatment; as there will be great irritation from the long continued use of such instruments, and a perpetual tendency, in the artificial passage, to close up.

On Imperforate Anus, consult *Sabatier's Medecine Operatoire*, tom. 4—*Callisen's Systema Chirurgiæ Hodiernæ*, tom. 2d, edit. 1815—*Ford*, in *Medical Facts and Observations*, vol. 1—*Richerand's Nosographie Chirurgicale*, tom. 3d—*Chamberlaine*, in *Memoirs of Medical Society of London*, vol. 5—*Wayte* in *Edinburgh Medical and Surgical Journal*, vol. 17—*A. G. Hutchinson's Practical Observations in Surgery*, 1826.

SECTION VIII.

Foreign Bodies in the Rectum.

INDIGESTIBLE articles often pass from the stomach along the intestines, and are arrested by the sphincters at the anus. Pieces of gristle, of bone, of sponge, of apple core, of toasted bread, and other similar substances, have been found within the rectum, and the cases reported. Still more numerous examples have been given of the lodgement of pins, needles, fish-bones, chicken-bones, all of which have excited more or less irritation, and, in some instances, laid the foundation of fistula in ano, of extensive ulcerations, and even death. Upon other occasions foreign articles have been forced into the rectum from without either by design, or by accident, sometimes producing death, at other times most violent symptoms—as exemplified in the case of the unfortunate Edward the Second of England, murdered by a red hot iron being thrust up the rectum, and in the celebrated case reported by Marchetti, where the but end of a pig's tail was forced up the rectum of a courtesan, and remaining for several days, had nearly destroyed her. “ Des etudians avoient projettè de jouer quelque mauvais tour a une fille publique; ils s'aviserent de lui mettre dans l'anús une queue de cochon qui étoit gelée; ils en couperent les poils un peu court, afin qu'ils fussent plus piquans et plus roides; ils la trempèrent dans l'huile, et l'introduiserent par l'extrémité la plus grosse et à force dans le fondement de cette fille, à la réserve de la longueur d'environ trois doigts qui resta à l'exterieur de l'anús: on fit diverses tentatives pour l'oter; mais comme elle ne pouvoit être tirée qu'à contre poils, les soyes entroient dans les membranes du *rectum*, et causoient à cette fille des douleurs inexprimables; pour les appaiser, on fit prendre à la malade divers remèdes huileux par la bouche, et on-tâcha de dilater l'anús avec un *spe-*

culum, assez pour retirer cette queue sans violence, mais on ne réussit; il survint des accidens énormes, un vomissement violent, une constipation opiniâtre, une fièvre, très ardent, et des douleurs très vive dans tout l'abdomen."*

Although not to be classed, with strict propriety, under the head of foreign bodies, yet great irritation and even extreme distress are not unfrequently occasioned by the lodgement of the *oxyurus vermicularis*, or ascarides, within the rectum—especially in children and old people. These animals, (which probably find their way into the stomach and intestines, through the medium of fruits and unboiled vegetables, and have been found out of the body by Pallas in the waters of Siberia, and by Dr. Barry in certain springs in Ireland,) are so enveloped in mucus whilst in the rectum, which they sometimes almost choke up, as scarcely to be reached by medicine, or the most stimulating injections. That they may be gotten rid of, however, or the irritation they produce very much alleviated, by means I shall presently point out, I have had frequent opportunities of proving for the last twenty years, and on that account I notice them in this place.



Removal of Foreign Bodies from the Rectum.

When, from more or less irritation, difficulty of passing fæces, a peculiar pricking sensation, within the rectum, whilst at stool, and at other times, a discharge of purulent matter and blood, from the anus, &c., there is reason to believe, that some foreign body occupies the gut, an accurate search should be made both by the finger and by instruments. If discovered, the extraneous article may then be removed by a pair of forceps or scoop. The latter instrument, such as is used commonly for extraction

* *Memoires de l'Academie Royale de Chirurgie*, tom. 3d., p. 78.—Edit. octav.

of bullets, is peculiarly adapted to the removal of hardened fæces, which often accumulate in the rectum, and become so impacted that the patient is unable to force them out. But pins, needles, fish and chicken-bones, &c., may be removed with more facility by the forceps than any other instrument. In the extraordinary case reported by Marchetti, and detailed above, a most ingenious and successful expedient for the removal of the pig's tail, and the only one that could have been practised with probable success, was resorted to—the introduction of the end of the tail, hanging from the rectum into a reed, the reed carried up the gut, made to press down the bristles, that stood like a chevaux-de-frise, and then the removal of the reed with the tail enclosed in its cavity. “Le sixième jour on eut recours à Marchetti: ce praticien instruit de tout ce qu'on avoit fait, inventa un procédé fort simple, mais fort ingénieux; il prit un roseau creux long d'environ deux pieds, il le prépara par une de ses extrémités de manière qu'il put l'introduire facilement dans l'anus, et enfermer entièrement la queue de cochon dans ce roseau, pour la tirer ensuite sans causer de douleur; dans ce dessein il attachà à cette queue, par le bout qui étoit hors du fondement, un gros fil ciré, et le passa dans le roseau; il poussa d'une main cette espèce de canule dans le *rectum*, et il retenoit de l'autre, le fil, pour ne pas repousser la queue en enfonçant le roseau dans le fondement: il parvint à enfermer entièrement cette queue dans la cavité du roseau, et délivra promptement la malade, tant du danger de la mort que de l'état cruel où elle se trouvoit; elle rendit sur le champ une très grande quantité de matières stercorales qui avoient été retenues pendant six jours par le corps étranger.” In ancient times, when barbed arrows were used instead of fire arms, an instrument somewhat similar to Marchetti's reed, was employed for removing them, in order to prevent the flesh from being torn during the extraction. There are many occasions, even now, when similar contrivances may prove useful.

For the removal of *ascarides* from the rectum, I have employed the bullet scoop, or a small instrument resembling a mustard spoon. I was first led to make the experiment by finding the disease to be exceedingly common, and sometimes productive of so much distress to the patient as to render life almost a burden. The scoop being oiled and introduced

into the rectum, was found to bring away one or more of these animals enveloped in its appropriate nidus, and to relieve at once the intolerable itching so annoying to the patient. Adults can use the instrument themselves, with the greatest facility, and are always directed to the spot where the animal is situated, by the itching and pricking sensation which it creates. Children will require the assistance of a physician or skilful nurse. Incredible quantities of these troublesome insects may be taken away in a short time, by this simple expedient—where medicines might be employed for months, and at last fail.

Consult *Memoires de l'Academie Chirurgie*, tom. 3d, *Précis Observations sur les Corps Etranger, &c.*, par M. Hevin, *Dictionnaire des Sciences Medicales*, tom. 7th, p. 35—*On Painful Constipation from indurated Fæces*, in *Lond. Med. Obs. and Inq.* vol. 4, p. 123—*Case of a Fork thrust up the Anus, and extracted*, in *Philosophical Transactions*, abridged, 1725—*Harrison's Case of Apple Core, forming a Fistula in Ano eight Months after being eaten*, *Memoirs of Medical Society of London*, 1796—*Blair's Case of hard Toast arrested in the Anus*, in *Medical Facts and Observations*, vol. 6—*Gregory's Case in which Death followed from a Fish-bone lodged for Years in the Rectum*, in *Monro's Morbid Anatomy of Stomach and Gullet*, p. 22, *Ed.* 1811.

CHAPTER VII.

DISEASES OF THE TUNICA VAGINALIS AND
TESTIS.

HAVING treated on a former occasion* of cancer and of fungus hæmatodes of the testicle, and described the treatment and operations necessary for each, some other affections of these organs will be noticed. These are hydrocele, hæmatocele, chronic enlargement of the testis, irritable testis, encysted testicle, tumours of the scrotum, &c. Among surgical writers, accounts will be met with, of the œdematous hydrocele or dropsy of the scrotum, of hydrenterocele or hydrocele combined with intestinal hernia, of encysted hydrocele of the spermatic cord, of the congenital hydrocele. These, however, are either the result of other diseases, or are so analogous, in many respects, to common hydrocele, as not to require minute consideration.

SECTION I.

Hydrocele.

THE tunica vaginalis is naturally bedewed with a thin serum, which, by lubricating its surface and that of the testicle, enables them to move freely upon each other. This fluid, when secreted in undue quantity, constitutes hydrocele—a disease of frequent occurrence, and met with in patients of every age and constitution. If attended to in the commencement, the tumour

* Vol. I. pages 191 and 197.

will be found to occupy the lower part of the scrotum, and gradually to extend towards the abdominal ring. In shape it is pyriform, and to the touch elastic—feeling like a bladder distended with water. When pressed upon, little or no pain is experienced by the patient, except at the posterior part of the swelling where the testis is situated. The rugæ of the scrotum generally remain unaltered, even in hydroceles of the greatest magnitude, and sometimes the tumour attains an enormous bulk. In ordinary cases, however, the tunica vaginalis seldom contains more than a pint of fluid. This fluid, in colour, is either perfectly limpid, or else yellowish. The disease is usually confined to one side. It is sometimes difficult to distinguish between hydrocele and other complaints that bear a resemblance to it. Much may be learned from the history of the disease. The hydrocele invariably begins below, and very gradually ascends. The swelling in sarcocoele, or scirrhus testicle, is uniform throughout, is accompanied with pain, is inelastic, and heavier when handled than hydrocele. When recent, hydrocele is generally transparent, if examined by placing the tumour between a lamp and the surgeon. From hernia it differs materially—the one commencing above, the other below. In hernia, moreover, an impulse is communicated to the finger when the patient is directed to cough. This is not the case with hydrocele. The causes of hydrocele are very uncertain. By some the disease is attributed to urethral excitement, by others to varicose enlargement of the spermatic vessels, to blows upon the scrotum, to rheumatism, cold, &c. I have met with it in infants immediately after birth. Hydrocele is often conjoined with enlargement of the testicle—constituting the disease called *hydro-sarcocoele*.

It occasionally happens that the cavity of the tunica vaginalis is occupied by one or more hydatids, or cysts filled with transparent fluid; and that the tumour bears so close a resemblance to common hydrocele as to be mistaken for it readily. A few cases of the kind I have met with, both in young and old subjects. Sometimes the two diseases exist simultaneously, and occupy the same tunica vaginalis. In other instances the hydatids are connected with the epididymis, or substance of the testicle, and protrude when the tunica vaginalis is opened by a trocar or lancet.

Hydrocele of the *spermatic cord* is now and then met with. It usually appears as a rounded, or oval tumour, in the site of the external abdominal ring; or it may be situated in the abdominal canal, between the internal and external rings. It is elastic to the touch, and retires in such a way, from the finger, as to give the idea of the existence of hernia, with which it is often confounded, even by experienced surgeons. A man forty years of age in the Alms-House Infirmary during the winter of 1833, had a tumour the size and shape of an egg, which occupied the left cord below the external ring. It was pronounced by some a hernia, by others, a varicocele. I was satisfied, however, by its not retiring with a gurgling noise, by its being free from pain and by its transparency and bluish colour, that it was a hydrocele of the cord, and so it turned out to be; for, upon thrusting a lancet into it, nearly an ounce of limpid serum was discharged.

Under the title of *congenital* hydrocele, a variety of that disease was first described by Vigurie and Desault, and was ascertained by them to be owing to the communication being kept up between the abdomen and tunica vaginalis, so that water accumulating in either of those cavities, might pass freely from one to the other. This form of the complaint is by no means uncommon; but is not confined to children. Hence, the term congenital is not strictly correct. It may be distinguished from common hydrocele by the fluid retiring into the abdomen when the patient is in the recumbent posture, and by its reappearing with more or less fluctuation in the erect position. The complaint is sometimes complicated with hernia.

Treatment of Hydrocele.

IN very young subjects, and in recent cases, I have sometimes succeeded in removing the disease by purgatives, and by bath-

ing the tumour repeatedly with a mixture of sal ammoniac and vinegar. Sir Astley Cooper recommends, in similar cases, a suspensory bandage moistened with muriate of ammonia and liquor ammoniæ acetatis, two drams of the former to six ounces of the latter; and, after using it for awhile, to add to the mixture tinctura lyttæ, or to apply tincture of iodine, in case the fluid is not absorbed. In the majority of instances, however, an operation will be required. This is either *palliative* or *radical*. The former may prove necessary when there is any doubt respecting the nature of the disease, or it may be performed to diminish the size of the swelling, and thereby enable a patient to pursue a journey without interruption. In a short time the fluid accumulates again; and, if necessary, the operation may be repeated. A common lancet, or a small trocar, answers equally well for the operation.

The *radical* cure of hydrocele has been attempted in various ways—by *laying open* the tunica vaginalis, by passing a *seton* through it, by applying *caustic* to the surface of the tumour, by *extirpating* a part of the tunica vaginalis, by the introduction of a *tent*, and by the *injection* of the cavity of the sac, after having drawn off its contents. The latter operation is the one practised by most modern surgeons, and when properly performed, is generally successful.

The patient being seated on the edge of a bed, or table, with his thighs separated, the operator sits before him, and grasps the tumour so firmly with one hand as to render it perfectly tense, while with the other he introduces a trocar of moderate size, covered by its cannula, obliquely upwards and inwards, into the front of the tumour, near its lower part.* The trocar, thus held, is made to penetrate the integuments of the scrotum, and the tunica vaginalis, to the depth of an inch and a half, and is then withdrawn, leaving the cannula behind, through which the fluid is immediately discharged. The nozzle of a syringe, or gum

* The opening is made in this situation, and the instrument directed *obliquely* with the view of avoiding the testicle, which is usually situated *posteriorly*. But it should be remembered that the testicle is sometimes placed in front, and will, therefore, be wounded if the above direction is followed. To avoid so unpleasant a consequence, the operator must endeavour beforehand to ascertain, if possible, its exact position.

elastic bag, is next adapted to the mouth of the cannula, and an injection, consisting of two parts of port wine, and one of water, thrown into the tunica vaginalis until it is distended to the size of the original tumour. The length of time the injection should be permitted to remain, must depend upon the patient's feelings. In general, a pain will be felt along the cord, extending into the abdomen; and when this becomes very severe, the wine and water must be evacuated; on the contrary, if the patient, as I have sometimes noticed, should experience no pain whatever, the injection may be renewed, and its strength increased. It only remains to withdraw the cannula, and close the wound by a bit of lint. In a few hours the parts swell, sometimes enormously, and may require the application of a poultice, the antiphlogistic system, and the recumbent posture. But the swelling usually subsides in four or five days, and a cure is accomplished through the medium of adhesion—the tunica vaginalis being made to coalesce with the proper coat of the testicle.

This operation, trifling as it is usually considered, is sometimes, from inattention on the part of the surgeon, followed by serious consequences, owing to the end of the cannula being permitted to slip from the cavity of the tunica vaginalis, and rest among the cellular membrane of the scrotum, into which the vinous injection will pass, and, by exciting most violent inflammation, cause gangrene and sloughing of the scrotum, and denudation of the testicles. This has repeatedly happened to surgeons of the first eminence, and should be most carefully guarded against. Sir Astley Cooper mentions an instance in which a patient, from this cause, died in about a week after the operation, and I myself have known of one case of the kind, and heard of another in this country.

If the operation of hydrocele, above described, should fail, as sometimes happens, it may be repeated; or the plan of Hunter may be pursued—which is simply to make an incision an inch long, into the upper and front part of the tunica vaginalis, evacuate the water, and sprinkle a little flour into the cavity. This generally excites the requisite degree of inflammation; and, after this purpose is accomplished, the flour may be washed out, or permitted to escape along with the pus.

This operation, however, is followed, sometimes, by violent

inflammation, and, in old people, by gangrene and death. In other cases the suppuration is so profuse that the tunica vaginalis is filled with matter. But I have known the same to follow, in one instance, the operation by injection. I performed, November 22d, 1835, the operation for hydrocele on a negro fifty years of age, at the Alms-House Infirmary. Nearly three pints of fluid were drawn off and the vinous injection thrown in. The wound made by the trocar healed up, but the swelling did not subside, and the patient's constitution was rapidly sinking. On the 22d of December, I pushed a lancet into it, and evacuated nearly a quart of thick offensive pus, and in a short time the man recovered perfectly.

I have had occasion to repeat the operation by injection two or three times in the same individual, and, at last, only have succeeded by using spirits of wine, or turpentine, along with the port wine; and although no injurious consequences followed, yet I am not inclined to recommend the practice, but have preferred, latterly, where the injection has failed, not to repeat it, but to resort to the *seton*, of which, under all circumstances, I entertain a very favourable opinion. The plan I pursue is very simple. The water being drawn off, in the usual way, by a trocar, I permit the cannula to remain, and pass through its cavity a small narrow seton needle, six inches long, armed with French braid, and, pushing the needle through the tunica vaginalis and scrotum, introduce the braid, and remove the cannula and needle—leaving a space of two or three inches between the orifices where the ends of the braid emerge, and tie the ends loosely together. Perfect cures having invariably resulted from this practice, in my hands, I have resolved, in future, where I have reason to believe that the requisite degree of inflammation will not be excited by the injection, to employ the seton at once, and from the first. Indeed, I see no good reason why it should not supersede the injection in all cases; for in the hands of the celebrated Pott, and others, it scarcely ever failed; and was never followed, so far as I am acquainted, with serious consequences. In general, it will be sufficient to permit the seton to remain ten days, or a fortnight, and during that time no attempt should be made to draw it backwards and forwards, which would only create unnecessary pain and inflammation.

Of the other methods of treating hydrocele—excision, caus-

tic, and the tent, I do not speak, because they are acknowledged, by all modern surgeons, to be either very severe or else inert.

Where *hydatids* occupy the tunica vaginalis, and fill it entirely, (a disease which cannot be distinguished, always, previous to operation, from common hydrocele,) the surgeon will discover that very little fluid follows the push of the trocar, and that a membranous bag will protrude immediately afterwards from the opening. In such a case, he will find it necessary to enlarge the orifice an inch or two, and dissect away with the knife, or scissors, the different hydatids he may meet with. The operation is tedious and painful, but generally successful.

In cases, however, where ordinary hydrocele is associated with two or three floating hydatids, the water must first be drawn off, and the injection, or seton, introduced, and each hydatid, afterwards pulled out as it shows itself, (which it generally does,) at the orifice, and cut off. Should any smaller hydatids remain, the inflammation that follows the injection or seton, will commonly obliterate them. If not, a small separate seton should, afterwards, be passed through them, and suffered to remain for a few weeks.

For *hydrocele* of the *spermatic cord*, either incision, or injection has been usually employed. The former is painful and apt to be followed by suppuration, and the latter almost sure to fail, even when repeated frequently. The *seton* is uniformly successful, and is decidedly, in every respect, the best remedy. Pott and other surgeons have reported cases where death has followed from laying open hydrocele of the cord.

Congenital hydrocele, as improperly termed, may be cured, sometimes, by a well contrived truss, which, by obliterating through the medium of adhesion the sides of the tunica vaginalis, shuts off the communication with the abdomen. Vigurie and Sir Astley Cooper report successful cases of the kind; but Desault, having tried the plan ineffectually, was induced to substitute another proceeding, more complicated, painful, and fraught, I conceive, with considerable danger. He first drew off the water by a trocar, then directing an assistant to make firm pressure at the groin, injected the tunica vaginalis with warm wine, and having afterwards carefully removed every particle of wine, lest it should find its way into the abdomen, by firm compresses over the scrotum and groin, succeeded, in a short

time, in obliterating the passage to the abdomen and in curing, at the same time, a hernia which happened to be conjoined with the hydrocele. This example, however, should not, I conceive, be imitated, on account of the risk of peritoneal inflammation from continuity of surfaces, and from the possibility of escape of the venous fluid into the abdomen. Should a truss effect a cure, by producing an hour-glass-like contraction between the belly and tunica vaginalis, it may afterwards become necessary to draw off the fluid from the latter by a trocar and perform some one of the operations for ordinary hydrocele. But experience proves that the fluid is sometimes spontaneously absorbed after the communication between the two cavities has been cut off. In cases where ascites and hydrocele are conjoined, the scrotum will be found a convenient place for the operation of paracentesis.

Hydrocele is removed, occasionally, by a blow upon the tumour, and, in other instances, by ulceration, or sloughing, from slow inflammation, or over-distention. I once performed the palliative operation upon a gentleman, and after the lapse of a few weeks, when the fluid accumulated again, ulceration took place at the spot pierced by the trocar, and left for a few days a fistulous orifice, from which the fluid drained off. In a few days the fistula closed and the fluid was again secreted, and again discharged, in a similar way; and after the process had been repeated several times, a cure was effected. Something similar occurred in a patient upon whom I operated for stone; for in twelve months after the operation the perineum ulcerated at the place of incision, and a lump of calculous matter was discharged from the bladder along with urine. The ulcer then healed up of its own accord, and the patient never had a return of his complaint.

SECTION II.

Hæmatocele.

THIS disease, as its name implies, is a collection of blood—situated either in the tunica vaginalis testis, within the tunica albuginea, or in the cellular membrane of the scrotum. It may arise, according to writers, from several different causes—from wounding one or more of the large veins of the scrotum in performing the operation for hydrocele,—from wounds of the vessels of the scrotum, during the operations of lithotomy and castration,—from rupture of branches of the spermatic vein,—from spontaneous rupture of a vessel within the tunica vaginalis, after the water of hydrocele has been drawn off,—from blows or injuries of the vessels of the testis, and consequent extravasation of blood within the tunica albuginea.

The disease may be distinguished, generally, from hydrocele, by its great weight and solid feel, by its want of fluctuation and transparency, by its often following the operation of hydrocele, or arising suddenly from a blow, and, sometimes, by the appearance of extravasated blood in the cellular membrane of the scrotum.

*Treatment of Hæmatocele.*

Unless the extravasation of blood should be very considerable, it will probably be absorbed in a short time. If, in this respect,

however, the surgeon is disappointed, an incision may be made into the part that contains it, and the coagulum extracted; after which, the parts will granulate and fill up. If any particular vessel continue to pour out fresh blood, it must be searched for and secured by ligature. During the winter of 1830, I attended a patient in the Alms-house Infirmary, whose scrotum was distended to an enormous size. Upon opening the tumour, I found a large collection of blood mixed with serum. Three weeks previously, the patient had undergone the operation for hydrocele, and the surgeon who performed the operation had, in all probability, wounded with the trocar some large artery or vein. The man recovered perfectly in a short time. Effusion of blood under the tunica albuginea, is considered by Pott, and some other writers, as requiring castration; but, as I conceive, without foundation.

There is, indeed, more reason to apprehend that the surgeon may be too prompt in performing this operation; for cases have been reported where the testicle has been extirpated and found upon examination perfectly sound. Sir A. Cooper, in particular, mentions an instance where a surgeon mistook a common hæmatocele for a diseased testis, and had so little curiosity, after castrating the patient, as not to examine the part. When dissected by Sir Astley, blood only was found in the tunica vaginalis, and the testicle in its natural situation and free from disease.

On Hydrocele and Hæmatocele, consult *Pott's Works*, by Earle, vol. 3—*A Treatise on Hydrocele*, by Sir James Earle, 1803—*Bell's Operative Surgery*, vol. 1, p. 193—*Ramsden's Practical Observations on Sclerocele*, 1811—*Dorsey's Surgery*, vol. 2—*Richerand's Nosographie Chirurgicale*, tom. 4, p. 262 and 258—*Scarpa on Hernia*, by Wishart—*Observations on the Structure and Diseases of the Testis*, by Sir Astley Cooper. 4to. 1830. London.

SECTION III.

Irritable Testis.

THIS disease has been particularly described by Sir Astley Cooper, under the title of irritable testis. It is a most severe and distressing affection, but, fortunately, not very common. Sometimes it follows hernia humoralis, or common inflammation of the testicle induced by injuries, though not, perhaps, until the inflammatory symptoms have disappeared for months; at other times it comes on without evident cause, and may occur in persons of vigorous and healthy constitution. But, on the other hand, it is occasionally, preceded, or followed, by paralysis, or derives its origin from the brain or stomach. That one or more of the nerves of the spermatic cord may be materially implicated in this affection is not improbable. The symptoms are excessive pain in coitu, pain in the groin and back, exquisite tenderness in the whole testicle, particularly upon the slightest motion of the testicle or any pressure that may be made upon it, by the clothes in walking. There is scarcely any general swelling, or enlargement, of the testicle, nor is the uneasiness or pain diffused throughout the gland. On the contrary, there is sometimes diminution of the testis, and the pain occupies a single spot or point and may shift from one part to the other in an instant. The cord is frequently the seat of suffering, and from it to the testicle, the pain darts backwards and forwards, like a flash of lightning. The recumbent posture, on the side opposite the disease, is the only one the patient can generally bear. Nausea, vomiting, mental dejection, and extreme bodily distress, are apt to follow long-continued attacks of the disease, and in some instances months and years wear away without any perceptible amendment or alleviation of the sufferings. When removed and examined by dissection, the testicle is found unaltered in structure, and apparently sound. In other cases, it is entirely

absorbed with the exception of the tunica albuginea, and tunica vaginalis. This *atrophy*, however, I have known to follow other affections of the testis, particularly hernia humeralis and that enlargement of the gland produced by cynanche parotidea, or mumps. In all the cases of the kind I have met with, one testis, or both have wasted away gradually, the pain has subsided and the patient recovered.

Treatment of Irritable Testis.

If the disease should reach the height I have described, it can seldom be removed except by the operation of castration. When only of a few weeks' duration, and the symptoms are moderate, benefit may be obtained, and a cure sometimes effected, by the internal use of carbonate of iron, arsenic, ammonia, quinine, camphor, opium, cicuta, stramonium, belladonna, compound decoction of sarsaparilla, and by the local application of blisters to the groin and thigh, and tincture of iodine, and pyroligneous acid, ice, &c., to the scrotum. Blood-letting, low diet, purgatives, and other parts of the antiphlogistic system, generally aggravate the complaint.

SECTION IV.

Chronic Enlargement of the Testis.

FROM inordinate indulgence in venery, or masturbation, from any urethral excitement, from exposure to cold, from fatigue or mental inquietude from intemperance, and from various constitutional causes, chronic inflammation is set up in one or both testicles, and is so insidious in its approach and so gradual in its advances, as often to escape the notice of the patient and to deceive the surgeon. In particular, even after the disease has existed for weeks, or months, the testicle may be handled roughly without exciting pain or any unpleasant sensation. Indeed, in many instances, the testicle attains a considerable magnitude, and yet is entirely devoid of uneasiness. The swelling commences in the epididymis, which slowly hardens and enlarges. From the epididymis it extends to the body of the gland, and both preserve their natural smoothness and shape.

Both testes may be simultaneously affected, or the swelling may remain stationary in one and increase in the other. With the swelling, a hydrocele is often conjoined. The patient's general health is apparently good, and he is seldom debarred from exercise, or prevented from attending to his business. In this state of the disease, it often happens that a blow, or some other injury, is received, or that the patient has been drinking to excess, or exposed to cold, and from that moment great pain, and swelling, take place in the testicle, which are soon followed by pain in the loins, febrile excitement, &c. By the use of appropriate remedies these symptoms wholly subside, and for weeks, or months, the patient remains, apparently, well. He is very liable, however, to a repetition of the attack, and should this occur

frequently, suppuration is established in the body of the testicle or epididymis, and the matter, of its own accord, at last discharged through the scrotum, or let out by the surgeon.

A sinus ending in a fistulous orifice, soon follows, and from this a discharge of seminal fluid issues, sometimes, in considerable quantity, and is kept up, not unfrequently, for many months. From the mouth of the sinus, granulations in a fungous form, sprout forth, and often become very luxuriant. Indeed, in this, and other respects, there is reason to believe that chronic enlargement of the testicle, corresponds with *fungus* of that organ, described in former editions of this work.



Treatment of Chronic Enlargement of the Testis.

In the commencement of this disease, or even after considerable swelling of the testicle has taken place, strict confinement for several weeks, to the horizontal position, elevation of the testicle above the pubes, and retention there by a bag truss, the application of leeches, followed up by cold saturnine solutions, or camphorated mixture, and vinegar, or the acetated liquor of ammonia, together with low diet, occasional purgatives, the internal use of mercury, and avoidance of venereal excitement or indulgence, will often effect a perfect cure. But, should the patient afterwards neglect himself, and have repeated returns of the complaint, and suppuration of the testis, discharge of semen through fistulæ, and fungous granulations follow, extirpation of the testicle, will, in many cases, be required, and, indeed, will often be insisted on by the patient. In other cases the fungous granulations may be repressed by caustic, or should be cut away with the knife, or kept down by pressure, whilst injections of solution of sulphate of copper and other similar articles are thrown into the sinuses, to consolidate their sides and close the fistulæ. It should

be remarked, however, that the operation of castration has often been performed, unnecessarily, for chronic enlargement of the testis, under the idea of its being a specific or malignant disease, which, in reality, it is not, as is proved by the circumstance of the cord not being liable to contamination, as it always is in the advanced stages of cancer of the testicle, &c.

SECTION V.

Encysted Testicle.

CYSTS, containing a yellow, transparent serum, or else a turbid gelatinous fluid, are found to occupy, occasionally, the substance of the testicle within the tunica albuginea. They vary in size, some being not larger than a shot, and others equal in bulk to a pistol bullet. The fluid contained in the larger ones is thick and muddy, and in the smaller transparent. Both the tunica vaginalis and albuginea are thickened, and, in cases of long standing, the substance of the testicle in a great measure removed, and its place occupied by the cysts. According to Sir Astley Cooper, these cysts are probably enlargements of the seminiferous tubes, and not animal hydatids.

Patients from eighteen to thirty-five years of age are most subject to the complaint, which, however, is rather uncommon than otherwise, and very liable to be confounded with other affections of the testicle, particularly with hydrocele. But the most striking symptoms of hydatid testicle are—conspicuous distention of the veins of the scrotum and spermatic cord, no tenderness, or pain, in the commencement of the disease, or even in the advanced stages, unless the part be forcibly squeezed, and then sickness of the stomach, pain in the groin, and that peculiar sensation which follows pressure on a sound testicle, arise. The testicle, too, retains its natural, or rounded shape, is heavier than usual, has a very obscure and limited sense of fluctuation, and the epididymis preserves, generally, its natural line of demarcation. In the end the tumour becomes enormously large, but the cord and inguinal glands are never contaminated. Lastly, there is no transparency in the tumour. This, together with absence of distinct fluctuation, and the rounded, instead of

pyriform, shape of the swelling will be sufficient, in most cases, to distinguish the disease from hydrocele. Nevertheless, the most experienced surgeons have been frequently deceived, and have confounded one with the other.

Treatment of Encysted Testicle.

Before giving a decided opinion, the surgeon should make it a rule to puncture with a lancet every tumour bearing a resemblance to encysted testicle. In case a few drops of fluid issue mixed with blood, the nature of the disease will, generally, be made manifest. It will then become a question whether castration should be performed or not. When the tumour is immensely large and is inconvenient, or so unsightly as to annoy the patient, it may be removed; but, on the contrary, when it remains stationary for years, and the patient's mind is not filled with apprehension as to the termination of the case, he should be advised to submit with Christian resignation to his misfortune and to palliate the complaint as long as possible. On the other hand, should he determine, after mature deliberation, to lose the testicle, the surgeon has it in his power to assure him of the safety of the operation, and that the disease (which is not of a malignant nature,) will not return. It may happen, however, to be conjoined with fungus hæmatodes, and in that case an operation will prove fruitless.

SECTION VI.

Tumours of the Scrotum.

SARCOMATOUS, and other indurated, growths are met with, occasionally, in the cellular texture of the scrotum, which sometimes are scattered about in the form of small tumours, which feel like a marble or piece of cartilage beneath the skin, being either firmly fixed or moveable; at other times the whole texture of the scrotum seems to undergo a change, becomes unusually corrugated, thickened, and finally converted into enormous indurated masses. Such are often seen in the West Indies and in Egypt, and interesting cases of the kind have been reported by Larrey, Titley and others, but are rarely met with in the United States. When a single sarcomatous, or adipose tumour occupies the scrotum, or the outer surface of the tunica vaginalis, or is imbedded in either of these textures, it often presents the appearance of a third testicle, and has been so considered by ignorant persons. An interesting case of the kind occurred several years ago in the practice of Dr. Heister, an eminent physician of Reading, in this state. The tumour had existed for a long time, was of the shape of a testicle, but much larger, and was so situated between the testes as to inspire a belief on the part of the patient and his friends that it was really a third testis. Upon being removed, however, by Dr. Heister, it was found to be lodged in a cyst between the scrotum and tunica vaginalis, and to consist of adipose and fleshy matter. The preparation, obligingly presented to me by Dr. Heister, is still in my cabinet.

Treatment of Tumours of the Scrotum.

Those enormous growths described by Larrey, Hendy, Titley, Delonnes, &c., although supposed to derive their origin from an incurable disease—elephantiasis—have been extirpated, nevertheless, with success. In particular, Titley removed, effectually, from a West Indian negro, a stupendous tumour, in the interior of which the genitals had long been buried, and which reached nearly to the ground, and weighed seventy pounds. Others of still greater weight and dimensions have been reported, and are said to have been successfully cut away. In performing such operations, the surgeon should endeavour, if possible, to ascertain the condition of the testes and penis, in order not to injure, or remove them unnecessarily. When small tumours occupy the scrotum or surface of the tunica vaginalis, they do not always require extirpation; but, when necessary, the operation is easily performed, and a cure soon effected. I have known, however, very large sarcomatous thickenings of the scrotum, and tunica vaginalis, and also enormous hydro-sarcoceles in West Indians removed in a short time by a change of residence. In December, 1816, Captain D—— was recommended to my care by Robert Harrison, Esq., United States consul for the Island of St. Thomas, on account of an immense scrotal tumour which involved each testicle and spermatic cord, and was complicated with hydrocele. The patient stated that from long residence in Martinique and other islands, where he had been exposed from the nature of his occupation to hardships, and had drunk constantly of rain water, which was often in an impure state, his disease, as he believed, was to be attributed. Whilst the patient was arranging his affairs and recruiting his health, to enable him to undergo an operation, the tumour gradually subsided, and in the course of two or three months was entirely absorbed—and all the parts affected restored to their natural state.

Consult, on Diseases of the Tunica Vaginalis and Testis, *Pott's Works*, by Earle, vol. 3d—*A Treatise on Hydrocele*, by Sir James Earle, 1803—*Bell's Operative Surgery*, vol. 1, p. 193—*Cooper's Lectures* by Tyrrel, vol. 2d, p. 86—*Observations on the Structure and Diseases of the Testis*, by Sir A. Cooper, p. 165—*Ramsden's Practical Observations on Sclerocoele*, 1811—*Richerand's Nosographie Chirurgicale*, tom. 4th, p. 258 and 262—*Observations on a peculiar Affection of the Testis, attended with the Growth of Fungus from that Organ, illustrated with Cases* by W. Lawrence, in the *Edinburgh Medical and Surgical Journal*, vol. 4, p. 257—*Wadd's Cases of Diseased Prepuce and Scrotum*, 4to. 1817—*Larrey's Surgical Memoirs*—*Case of Extraordinary Enlargement of the Scrotum*, by J. M. Titley, in *Medico Chirurgical Transactions*, vol. 6, p. 73—*Delonnes' Case of Charles Delacroix*, in *Richerand's Nosographie Chirurgicale*, tom. 4th, p. 315.

CHAPTER VIII.

Diseases of the Penis.

A MISTAKE into which writers, as well as practitioners, are extremely apt to fall,—that the penis, with one or two exceptions, is subject only to specific disease—should be corrected. Possessing the same texture and organization, (modified by certain peculiarities) as other soft parts, why should it not be liable to the same infirmities? That it is so, experience, our safest guide, has, sufficiently, proved; for, wounds and other injuries, simple and erysipelatous inflammations,—excoriations—abscesses,—ulcers, simple, irritable, and indolent,—warts,—tubercles,—tumours, sarcomatous, encysted, steatomatous—herpetic and other eruptions, totally unconnected with syphilitic taint, or with other specific vitiation, sometimes the result of sexual intercourse, at other times entirely independent of it, the consequence often of abrasion, or mere mechanical injury, have been, always, more or less common, in every country and in every age. It is not my intention, however, to treat of all these affections, but chiefly of simple ulcerations, of phymosis, paraphymosis, &c. Chancre, or the true syphilitic sore, has been noticed on a former occasion.*

* See vol. 1, p. 226.

SECTION I.

Wounds of the Penis.

THE penis is liable to incised, lacerated, contused, gun-shot and other varieties of wounds. They may be the result either of design or accident, and numerous instances have been reported where maniacs, and persons under the influence of religious phrensy or hallucination, have removed both the penis and testicles. An extraordinary instance where an attempt was made, under a different feeling, to inflict a punishment of this description, occurred not long since, in the practice of an eminent surgeon of New York. A woman who had long lived unhappily with her husband, and from whom she had been separated for a considerable time, became, apparently, reconciled to him, and through the intervention of friends the parties consented to renew their nuptial intercourse. Prompted, however, by jealousy and a diabolic spirit, the virago, having provided herself with a razor, took it to her bed, and while her unfortunate Abelard was in the act of consummation, seized the penis, and with her weapon nearly severed it from his body.

The penis has been shot off in duels, or swept away by cannon or musket balls or grape-shot, or so bruised and lacerated by these and other missiles, that it has afterwards sloughed and been lost. A severe bruise, or contusion, may likewise produce a different effect or lay the foundation of a specific disease as in the following case. "I. Wallace," says Sir Everard Home, "a married man, thirty-seven years of age, stout-made, subject to no general or particular complaints, and by profession a sailor, was admitted into St. George's Hospital, under my care, November 18th, 1803. About four years since, during a violent storm at sea, the main top-mast was shivered, and the upper portion was swinging backwards and forwards. It was

necessary to cut away the upper piece, and Wallace was sent aloft for that purpose. He had on a pair of loose trousers at the time. The rolling of the ship was very great, which increased the motion of the mast, and while he was clinging to the standing part, his glans penis was caught between it, and the loose piece; he immediately fainted away and fell into the round top, from whence he was carried to the deck. On recovering, he was informed by his companions that when they first took him up his glans penis was as flat as a half crown. The body of the penis and both testicles, as well as the glans, began to inflame and swell, and were extremely painful. He kept his bed for three weeks, at the end of which time the glans had recovered its natural size and figure, having only a small pimple on that part to which the frænum is attached. This was considered of no consequence, and was not at all troublesome until his arrival in England, six months afterwards, when it began to ulcerate and become very painful. It is proper to remark that he never had the venereal disease, and from the time of the accident never had intercourse with his wife or any other woman.”* From that period the ulceration increased, assumed the cancerous form, involved the greater part of the penis and groin, and after the lapse of a year proved fatal.

Treatment of Wounds of the Penis.

In cases of incised or lacerated, wounds of the penis, the hemorrhage should be arrested by picking out the vessels with the tenaculum, or needle, and tying them, or by introducing a catheter into the urethra and making firm compression with a bandage on the penis. After the hemorrhage has ceased, the edges of the wound must be drawn together by the interrupted suture, and supported by adhesive straps. The bandage should

* Home on Cancer.

then be slackened or removed, as, if long continued, it will be apt to cause swelling and to excite erections. When the urethra is divided and the penis nearly cut through, as in the New York case, the catheter must be continued until reunion is established; otherwise, effusion of urine and sloughing may follow. Contused wounds of the penis will require poultices and fomentations, and after full benefit has been derived from these, should ulcerations remain, mild dressings, such as are used in simple ulcers in other parts of the body, may be resorted to. But, in all injuries of the penis, an important indication is to repress erections—by the internal use of camphor, dulcamara, &c.

SECTION II.

Ulcers of the Penis.

THE loose skin covering the glans, as well as that on the body of the penis, is subject to phlegmonous inflammation and abscess, which seldom, however, forms a large tumour, but upon breaking, or being let out with a lancet, discharges freely, and leaves an ill-conditioned sore, with an indurated margin, and excavated edge. The whole aspect of the ulcer, indeed, is at first so unfavourable as to cause it to be mistaken for chancre; though the rapid progress towards amendment, and the speedy filling up of the sore, will soon evince its true character.

The *Ulcus Erraticum* is met with, almost invariably, in persons of bad constitution, in dram drinkers, and in those who have suffered from the abuse of mercury. It may follow sexual intercourse or not, and is distinguished, generally, by this peculiarity—that the sore, which usually occupies the body of the penis, ascends in a spiral form, and, while it heals below, breaks new ground above, and in this way may encircle the penis, reach the groin, and pubes, and devastate them. The edges of the ulcer are everted and indurated, the granulations foul, and the pain severe and burning.

Psoriasis Preputialis is an affection almost peculiar to those individuals who have the prepuce unnaturally long, tender, and succulent. It appears in the shape of deep fissures, or cracks, which pervade the edges of the prepuce, discharge at first a cohesive, and afterwards a purulent matter, bleed freely upon being irritated, are excessively tender or painful, and difficult to heal.

Herpes Preputialis differs from the foregoing affection in toto. It commences in the form of vesicles, which, upon breaking, leave, when situated on the inner surface of the prepuce, a small round yellowish white ulcer, and when it occupies the outer skin of the prepuce, forms a scab. Each vesicle has its corre-

sponding sore, which often unites with those adjoining it, until one unbroken surface of ulceration is established. From experiments made by Mr. Evans, it appears that the sore is not contagious. The same writer imputes the disease to derangement of the digestive organs.

Excoriatio, or abrasion of the cuticle of the glans penis or prepuce, may be the result of inordinate friction, of preternatural tenderness of parts, of undue secretion of that whitish, cream-cheese like, sebaceous matter, which seems almost peculiar to certain persons, of filth, or want of accurate ablution, of connexion with foul and unwholesome women, particularly such as have laboured for years under fluor albus and other acrimonious discharges, of extraordinary inequality of size between the male and female genitals, &c. From any of these causes, troublesome ulcerations may arise, and are often confounded with syphilitic sores. But their external characters are sufficiently marked, in general, to enable a careful surgeon to distinguish them from other ulcerations. In particular, these ulcers are superficial, irregular, in separate patches, of a yellowish hue, in the commencement, but surrounded, in the advanced stage, by a red areola. Extraordinary itching, together with undue serous or purulent secretion, followed, in some instances, by sympathetic enlargement of the inguinal glands, are the remaining symptoms.



Treatment of Ulcers of the Penis.

Phlegmonous inflammation of the penis is rarely susceptible of resolution. The sooner, therefore, the matter is evacuated by a lancet, the better. An emollient poultice of bread and milk, ground flax seed, and particularly of the powdered bark of slippery elm, may then be applied, and renewed frequently for a day or two. Afterwards, the mildest unctuous dressings and lotions may be employed. Should fungous granulations arise, the sulphate of copper and lunar caustic will be required.

Ulcus Erraticum, like the common irritable ulcer of other parts, frequently proves refractory. It should be coaxed and humoured by soothing and sedative lotions, such as the acetate of lead and sulphate of zinc blended with gum Arabic and opium. Very weak solutions of argentum nitratum, and nitric acid, extremely diluted, will also prove useful. Acrid and stimulating applications generally fret and annoy it. The blue pill, as an alterative, and great attention to diet, with rigid observance, in plethoric patients, of other parts of the antiphlogistic system, will sometimes do more good than all the local remedies that can be thought of. In patients prostrated by intemperance, or other causes, a system of support, or nourishment, must be instituted, and corresponding applications to the sore, and internal medicines employed.

For *Psoriasis Preputialis*, various astringent lotions and ointments are generally used, and, according to Evans, the best application is the unguentum hydrargyri nitrati, reduced to one-half its ordinary strength.

Herpes Preputialis is benefited by attention to diet, by the occasional use of gentle purgatives, and by the mildest local applications. Keeping the parts perfectly clean, and suffering them, when disposed so to do, to form a scab, will effect a cure in a very short time.

Simple *Excoriations*, unconnected with specific disease, may be removed speedily, by guarding against erections, by the use of simple ointments perfectly fresh, by moderately astringent lotions, and, when the sores become indolent, by gentle, occasional, touches of argentum nitratum, and weak solutions of corrosive sublimate mixed with spirit of lavender or alcohol.

SECTION III.

Phymosis.

THERE are two varieties of this disease—the *natural* and *preternatural*. The former exists at birth, and is therefore congenital; the latter may occur at any period of life. In both cases the prepuce is contracted in front, and cannot be drawn backwards over the glans penis.

Natural phymosis is a very common complaint, and met with under two or three different forms. Sometimes, though rarely, the extremity of the prepuce is perfectly closed, and the urine cannot pass off, but collects between the glans and prepuce, forming a large bag or tumour. The disease is of course discovered a short time after birth, but is often not understood, and from this cause several infants have perished that might have been saved by a trivial operation. Another form of natural phymosis is that in which an opening exists at the extremity of the prepuce, but so small, as not to permit the urine to escape from it with the same rapidity it issues from the urethra. Consequently, it collects between the prepuce and glans, and distending the former to a great size, is then forced off gradually in a very fine stream, and to a great distance. If the disease should continue in this state for several years, as I have known to happen, pus and calculi may collect within the cavity of the distended prepuce, and keep up a constant irritation. But in most instances, there is no impediment to the flow of urine, no extraordinary elongation of the prepuce; yet the skin is so closely contracted around, as to prevent the patient from uncovering the glans penis. From this, other inconveniences result. A whitish sebaceous matter collects in large quantity between the glans and prepuce, and excites so much irritation, as to produce a disease resembling gonorrhœa—with which it is often confounded. Besides this, the inflammation excited by this,

or any other cause, may produce an adhesion between the glans and prepuce, which can only be relieved, and that not always, by a most severe and tedious dissection.

Preternatural phymosis is commonly the result of inflammation of the prepuce, by whatever cause induced. The disease often accompanies severe gonorrhœa, extensive chancres, and venereal warts. Sometimes matter accumulates behind the corona glandis, and is followed by ulceration of the prepuce, and a protrusion of the glans through the opening. The inflammation attending preternatural phymosis, is sometimes of the erysipelatous kind. Extensive sloughing of the prepuce is frequently the consequence, in bad constitutions, of the continued exhibition of immoderate quantities of mercury.

Treatment of Phymosis.

Natural phymosis, if it exist at birth, and be complete, will require an immediate operation, in order to save the infant's life. A puncture with a common lancet in the most prominent part of the tumour, may answer every purpose, as the stream of urine will afterwards prevent the opening from closing. When the prepuce has become distended, from repeated collections of urine, the small opening in its extremity may be either enlarged, or the superfluous bag amputated. The latter will prove the most effectual, and should be, generally, resorted to.

A simple phymosis, when only inconvenient to the patient by impeding copulation, may be relieved by slitting up the prepuce at its middle as far as the corona glandis. The operation can be performed with a sharp-pointed bistoury, or still better by the sheathed knife employed by Dr. Physick for fistula in ano. Hemorrhage sometimes follows the incision, but in general is easily suppressed by a dossil of lint. Before the parts are dressed, the surgeon must take care to tack the two layers of skin to each other by a single stitch of the interrupted

suture. The edges of the prepuce, thus divided, retire from each other, and after they are healed, become continuous, and resemble the borders of a prepuce naturally formed. This has been denied by some surgeons, who allege that two flaps or angles are left, which afterwards prove very inconvenient to the patient. I have performed the operation very frequently, and never experienced such a result.

Preternatural phymosis, when complicated with gonorrhœa or chancres and attended with high inflammation, should never be touched with the knife. The best remedies, under such circumstances, are local blood-letting, emollient poultices, fomentations, and accurate ablution of the glans by means of a syringe. The continuance of mercury will prove immensely injurious. After the inflammation has entirely subsided, if adhesions should have formed between the glans and prepuce, uniting them firmly to each other, an attempt may be made to separate them by dissection, provided the patient is willing to encounter a most severe operation, (one compared by Petit "to the skinning of an eel,") rather than submit to his misfortune.

SECTION IV.

Paraphymosis.

PARAPHYMOSIS is the reverse of phymosis—the prepuce being retracted behind the corona, leaving the glans uncovered. The disease may be either congenital or acquired, but the latter is the most common. Sometimes it is the result of the successful retraction of the prepuce in cases of phymosis; but generally it proceeds from inflammation induced by syphilis or gonorrhœa. So extensive is the swelling, in some instances, and so great the constriction produced by it, that the glans penis, or prepuce, occasionally mortifies and drops off. This termination, however, must be considered as comparatively rare.

*Treatment of Paraphymosis.*

If called in time, or before the swelling attains a great height, the surgeon may often succeed in restoring, by steady pressure with the fingers, kept up for several minutes without intermission, the prepuce to its natural situation. The application of very cold water to the parts will also contribute towards the same end. Punctures, too, when there is much œdema, as generally happens, afford great relief, by evacuating the serum and reducing the swelling. This treatment, together with an observance of the antiphlogistic system, will usually effect a

cure in a short time; should this not prove to be the case, and gangrene of the parts be likely to follow, the division of the stricture must be attempted. To accomplish this, a fold of the skin should be raised and cut through, a director pushed beneath the stricture, and the latter divided by a bistoury.

On Phymosis, Paraphymosis, and other Diseases of the Penis, consult *Petit's Traité des Maladies Chirurgicales, et des Operations qui leur Conviennent*, tom. 2—*Hunter on the Venereal*—*Cooper and Travers' Surgical Essays*, part 1, p. 145—*Richerand's Nosographie Chirurgicale*, tom. 4, p. 328—*S. Cooper's First Lines of the Practice of Surgery*, vol. 2, p. 176. *Wadd's Cases of Diseased Prepuce and Scrotum*, 4to. London, 1817—*Pathological and Practical Remarks on Ulcerations of the Genital Organs*, by James Evans, Surgeon to his Majesty's 57th Regiment. London, 1819.

CHAPTER IX.

DISEASES OF THE URETHRA AND BLADDER.

VOLUMES have been written on these subjects; and there is scarcely an eminent surgeon of any age who has not devoted some portion of his writings to their explanation. This will show the importance of these diseases, and the difficulties encountered in their treatment. In a work professedly elementary, it will not be expected that more than a very general sketch on such topics can be furnished. Ample scope, however, must be taken in the lectures—such, I trust, as will abundantly supply any deficiency that may be here met with. The diseases of the urethra and bladder, that remain to be considered, are stricture, fistula in perinæo, enlarged prostate, retention and incontinence of urine, and stone in the bladder.

SECTION I.

Stricture of the Urethra.

THIS is a very common complaint; more common, indeed, than is generally imagined. It may proceed from various

causes—from gonorrhœa, or the remedies employed in the cure of that disease; from external violence; from irritation within the urethra, produced by the passage of calculi, or the application of blisters to the perineum or other parts of the body; from excessive indulgence in venery, or unnatural prolongation of the venereal act; from enlargement of the prostate gland; from stone in the bladder, &c. It is somewhat remarkable, however, that the disease seldom makes its appearance until years have elapsed, and the effect of the causes above enumerated has appeared to cease. Many surgeons question the propriety of referring the origin of stricture to gonorrhœa, without, I conceive, sufficient foundation; though it must be acknowledged that the disease is sometimes met with in very young boys, and in adults who have led the most exemplary lives.

Strictures have usually been divided into two kinds—the permanent and spasmodic. To these Mr. Hunter added a third variety—which is alleged to consist in a combination of the two. Permanent stricture may be said to consist of a thickening or change of structure in the urethra, induced by preceding inflammation. That spasmodic stricture frequently exists, there cannot be the smallest doubt, though it is still a question whether the spasm should be referred to the muscularity of the urethra itself, or to the muscles surrounding that canal; a question, however, in a practical point of view, of comparatively small importance. Yet I must confess my willingness, for various reasons, to subscribe to the latter doctrine.

There is seldom much variation in the *seat* of a stricture; which is usually found behind the bulb of the urethra—about seven inches from the extremity of the glans. At the distance of four or five inches, also, and three inches and a half, measuring from the outer orifice of the urethra, strictures may be often discovered. Sometimes the orifice itself is the seat of stricture. Most patients have but one or two strictures, others four or five.

Strictures differ from each other in *extent* and *consistence*. The most common form of the disease is that which resembles the effect of a thread tied round the canal; it is likewise the most simple variety of stricture. Sometimes the canal of the urethra is irregularly contracted or thickened, in one or more places, to the extent of an inch and upwards. The simple

thread-like stricture, which does not always run in a circular direction, but sometimes splits and branches, may by irritation or bad treatment be converted into a callous induration. When examined by dissection, most permanent strictures will be found to consist of a dense, pure white, fibrous substance, like gristle—the result of previous and repeated depositions of coagulable lymph.

The *symptoms* of stricture of the urethra, are *constitutional* and *local*. Among the former may be enumerated, disorder of the digestive functions, general irritability of the system, various mental emotions, severe chills followed by high fever and profuse perspiration. All patients, however, are not subject to the febrile paroxysm. The most common local symptoms are, a slight discharge of matter from the urethra; a frequent desire to evacuate the urine, which issues in drops, or in a forked, twisted, wiry or thread-like stream; nocturnal emissions; scalding of the urine; uneasiness about the anus and perineum. Persons troubled with strictures, are extremely liable to cold, which greatly aggravates the symptoms. Excess in eating or drinking will produce the same result. During copulation, it frequently happens that a stricture, by interrupting the flow of semen, occasions it to be forced backwards into the bladder, from which it is afterwards discharged the first time the patient makes water.

Stricture is often confounded with other diseases; especially with gonorrhœa, gleet, stone in the urethra or bladder, enlarged prostate, spasm of the muscles of the perineum, irritation or inflammation of the lacunæ, intermittent fever, &c.



Treatment of Stricture of the Urethra.

In the treatment of this disease, the first object of the surgeon should be to ascertain the situation and extent of the stricture.

This may be done by a bougie, catheter, or urethra sound.* A soft white bougie of moderate size, well oiled, will excite as little irritation as any other instrument, and is well calculated, when softened by the heat of the urethra, to take an exact impression, with its point, of the form of the obstruction, and of its precise situation. Over the bougie, however, in many instances, the urethra sound possesses a decided advantage, since from its metallic nature, and the small size of the wire rod, it communicates a vibration to the surgeon's finger, and passes easily along the urethra, while the ball at its extremity catches readily upon any irregularity of the canal, and in this way detects the slightest obstacle. With this instrument, moreover, the situation of several strictures may at the same time be ascertained—an advantage which the bougie does not combine.

Having satisfied himself of the nature of the stricture, its position and extent, the surgeon must next determine upon the means to be employed for its removal. There are three or four methods in common use—dilatation of the stricture by waxen, metallic, or gum elastic bougies,† destruction of it by the lunar or vegetable caustics, and its division by a stilet. Each is adapted to particular cases. When the strictures are numerous and of considerable length, neither the caustic nor stilet can be employed to advantage, and dilatation by the bougie must be mainly depended upon. In using this, the surgeon should make it a rule to proceed as gradually and cautiously as possible, commencing with an instrument of moderate size, such as will pass readily through the strictures without giving pain or exciting

* An instrument invented by Sir Charles Bell, made of silver wire, twelve or fourteen inches long, having at one end a ball, at the other a ring; the former intended for the stricture, the latter for the surgeon to hold by while the instrument is introduced.

† The finest bougies I have ever seen, were prepared by the late Dr. Balfour, of Norfolk, Virginia; a gentleman remarkable for his intellectual endowments, amiable character, and mechanical ingenuity, and whose death will long be deplored by the inhabitants of the district in which he resided. The wonderful dexterity which he possessed in the manufacture of instruments, of every description, is evinced in the splendid collection of *splints* and *bandages*, presented to the museum of our university, in 1830, by his son, Dr. Eleazer Balfour, a most promising young practitioner of Norfolk. Many of the instruments referred to are of exquisite finish and workmanship, such as would puzzle, if not defy, the best regular mechanic in the country to imitate or equal.

hemorrhage. It should be worn morning and evening, while the patient is in bed, or at regular intervals during the day, taking care not to continue it too long, but, on the contrary, to withdraw it when undue irritation is excited by its presence. Having derived full benefit from the use of one instrument, others should be introduced, proportioned in size to the extent of the dilatation—being gradually increased. In many instances, the constant use of these instruments for a few weeks will effect a perfect cure, in other cases, months or years will elapse, before the patient derives the necessary relief. Silver bougies, when well made, are better adapted to the dilatation of a stricture than most others. Many patients, however, experience great benefit from the use of the flexible metallic bougie. For very long and narrow strictures, I have used, with much advantage, for many years past, fine, highly polished, and very flexible whalebone bougies.

Caustic has long been employed in the cure of strictures. It was a favourite practice with Mr. Hunter, and has since been highly extolled by his relation Sir Everard Home. I have employed the remedy for many years, sometimes advantageously, at other times, with manifest aggravation of the symptoms. From all I have seen, I am disposed to conclude, that it is only adapted to strictures of small extent—such as the thread-like stricture. That much mischief has resulted from its indiscriminate and injudicious application, I well know; but its strongest advocates, also, confess, that in their own hands, false passages, hemorrhage, great irritation, severe paroxysms of fever, and other ill consequences, have often been induced. These remarks will apply to the vegetable as well as lunar caustic, although the former has been considered by some writers to be milder in its operation, and to act upon a different principle from the lunar caustic. When a stricture is very small, and situated near the extremity of the urethra next to the glans penis, and there is reason to believe, that one or two applications of the caustic will go through, it may be applied in the following way. The surgeon takes a common soft bougie, oils it, carries it nimbly down to the stricture, keeps it in contact with it a few seconds, and marks with his finger nail the bougie at the external orifice of the urethra before he withdraws it. Another bougie, composed of firmer materials, is next taken,

a hole, about the eighth of an inch in depth, scooped from its extremity by a sharp penknife, and a portion of lunar caustic inserted into it, and secured by squeezing together the edges of the hole—leaving the central part of the caustic a little exposed. A mark corresponding to that on the soft bougie, (which is intended to designate the depth of the stricture from the external orifice,) is then made upon the caustic bougie, and the latter, at once oiled and carried down to the stricture, and kept in contact with it, for one or two minutes, or for a shorter period, should the patient complain of its severity. In two or three days' time the operation may be repeated, and occasionally within the same period until the stricture gives way, or is entirely removed.

The *stilet*, although used by some of the older surgeons in the cure of stricture, was not practised in modern times, until recommended by Dr. Physick. In 1795, he first performed the operation, and has ever since continued to employ the same means, and oftentimes with the greatest success. I myself have likewise succeeded, in many instances, in effecting a perfect cure, after bougies, the caustic and other means, have entirely failed. Before the clinical class in the Alms-House Infirmary, some years ago, I perforated, with the stilet, a stricture of long standing, near the bulb, which had resisted for seven years the efforts of different surgeons, to introduce an instrument of any description into the bladder. In three minutes after the division of the stricture, a catheter entered, and the patient experienced the greatest possible relief. What renders this plan of treating strictures the more valuable, is the circumstance of the operation being attended with very little pain, and with no risk, provided the operator possess an accurate knowledge of the structure of the parts. The instrument used by Dr. Physick, is a sort of lancet concealed in a cannula, that may be pushed forward or retracted at pleasure. When it becomes necessary to pierce a stricture situated near the bulb of the urethra, a curved instrument should be used.* Upon several occasions, I have used with success, in strictures seated near the anterior part of the urethra, a common couching needle, rendered blunt at the point, and sharpened at its edges. After

* Drawings of these instruments may be seen in Dorsey's Surgery, vol. 2.

the division of the stricture, a bougie or catheter must be worn for some time, to prevent the passage from closing again.

From the use of bougies or the caustic, it very often happens that an unnatural route or *false passage* is created. This is owing, generally, to unskilfulness on the part of the surgeon, or patient himself, or to the use of instruments so small as to enter the lacunæ of the urethra, instead of following the natural course of the passage. When once established, a false passage is extremely difficult to remove, and, on this account, great pains should be taken to guard against its formation. To the patient the disease is inconvenient, chiefly by preventing the easy introduction of the bougie or catheter, and sometimes, on this account, dangerous, in cases of retention of urine. The best plan, in general, of destroying the unnatural route, is to use a bougie larger than the one by which the disease was created, and to bend its point towards that part of the urethra opposite to the false passage. A large catheter, very much curved, will also pass, in many instances, where no other instrument can be made to follow the natural course of the urethra. Mr. Hunter was in the habit, sometimes, of performing an operation for the removal of this disease; fortunately, however, such an expedient can rarely, if ever, prove necessary. But in three or four instances, I have succeeded in establishing the natural course of the urethra, where the false passage depended upon the resistance of a stricture, by piercing the stricture with the stilet, and afterwards passing a catheter through it, and suffering it to remain in the bladder for several days.

Formerly, a few English surgeons of eminence were in the habit of *forcing* strictures, by driving bougies and catheters through them, and making an entrance by violence into the bladder. A similar practice for several years past has prevailed in France, where an instrument called *sonde conique*, is much in vogue. I will not condemn the proceeding, because I do not know it, from experience, to be hurtful; but I confess I have a feeling amounting to prejudice against it. Of Mr. Arnott's method of curing strictures, by the peculiar instruments named *dilators*, I have nothing to say—having never tried the plan.

SECTION II.

Fistula in Perinæo.

FROM strictures of the urethra, from blows and other injuries, fistula in perinæo is frequently produced. In proportion as a stricture increases, the urethra, at the diseased part, is diminished; while that portion of the canal immediately behind the obstruction, by the efforts of the bladder and the continual propulsion of the urine against it, is enlarged. The irritation thus kept up gives rise to inflammation and ulceration, and an opening is at last made through the urethra, and communicates with the cellular membrane surrounding it. Into this opening the urine finds its way and lodges, and by its acrimony increases the irritation until an abscess is formed; which gradually enlarges, and finally discharges itself externally. The urine then passes out mixed with matter, both from the opening in the perineum and from the external orifice of the urethra. In the course of time, however, it frequently happens that the strictured part of the canal, no longer feeling a forcible impulse from the stream of urine, gradually closes, and is finally obliterated, after which the whole of the urine is evacuated through the fistula. Sometimes, instead of the ulcerative process first commencing on the internal surface of the urethra, an abscess is formed from irritation in the cellular membrane exterior to the canal, into which the ulceration at last extends, and throws the two cavities into one. Fistula in perinæo sometimes proceeds from a rupture of the urethra, (produced by external violence, or by the force of the urine upon the inflamed and tender part of the canal behind the stricture,) and the urine is instantly sent abroad into the loose cellular membrane of the perineum and scrotum, where it forms an enormous distention or tumour, and excites most violent inflammation, that terminates in a few

hours in gangrene, and sloughing of the scrotum—leaving in many instances, the testicles and urethra bare, and endangering the patient's life. There is seldom more than one fistulous opening communicating immediately with the urethra, but from it numerous sinuses generally extend in various directions; and in cases of long standing, it is not unusual to find the cellular membrane of the scrotum, and of all the other parts through which the urine meanders, greatly condensed and converted into indurated tumours, upon the surface of which may be found innumerable small holes, that discharge offensive urine and matter—rendering the patient disagreeable to himself and disgusting to his neighbours.

Treatment of Fistula in Perinæo.

It will appear obvious, from what has been stated, that when fistula in perinæo depends upon stricture, the first indication in the treatment of the disease should be to get rid of the obstruction, and enable the stream of urine to regain its natural route. This, if the canal anterior to the fistula is obliterated, can be accomplished only by an operation, and the one which I have usually performed, and frequently with success, is as follows.

The urine being retained in as large quantity as possible, the patient is placed upon his back on a table, covered with a mattress or blankets, the thighs bent upon the pelvis, and the legs upon the thighs, separated and supported by an assistant on each side. A female catheter or sound is then carried down to the stricture, and there held firmly by another assistant, while the surgeon introduces a probe into the largest fistulous orifice he can find, and the one nearest to the stricture, and endeavours to feel with it the extremity of the sound, through the walls of the urethra. An incision, proportioned in length to the extent of the disease, is next made into the perineum, along the course of the probe, until the urethra or its remains are laid bare, when

the operator will be enabled to cut upon the extremity of the sound, and divide the stricture. The sound may be, afterwards, withdrawn, and a gum elastic catheter introduced at the glans penis, and carried along the urethra into the bladder, where it should be suffered to remain for several days. As soon as the natural route for the urine is thus re-established, the fistulæ diminish, the indurated cellular membrane contracts, the wound begins to fill up, and is finally closed, and, through the medium of granulations, which form around the catheter, a new urethra is created; after which, the sinuses all heal, and the patient recovers. In many instances, the operation is extremely difficult, and very painful, especially in irritable patients, and those who have suffered a long time from the complaint. Cases, indeed, are reported of patients who have died under the operator's hands.

When a fistula in perinæo is complicated with *pervious* stricture, an attempt should be made by bougies, caustic, and other means, to destroy the stricture, or enlarge it, and afterwards to heal the fistulous opening by escharotics; the best of which, for this purpose, is the argenti nitratum. Sometimes a fistula in perinæo will contract to the size of a hair, and in that state remain for years, now and then shedding a few drops of urine. For this state of the disease, I have found a blister the best remedy.

Effusions of urine into the cellular texture of the scrotum, from rupture of the urethra, require very decisive measures. Aware of the nature of the disease, the surgeon should lose no time in making very free punctures and incisions into the skin and cellular membrane, from which he will soon find the urine to issue in considerable quantity. When performed in time, the operation may save the parts from sloughing. This, however, is seldom the case. But it is astonishing how much nature does for the patient under these circumstances: for even after the testicles have been entirely divested of integument, a new scrotum is almost always formed out of the adjoining parts. The fistula, in general, heals spontaneously.

SECTION III.

Enlarged Prostate.

ALTHOUGH the prostate gland is subject to inflammation, abscess, scrofulous enlargement, and collections of urinary calculi within its substance, these affections are rare, compared with that commonly known under the name of scirrhus. To this disease old people are almost exclusively liable, and so frequent is it among them, that, according to Sir Everard Home, few subjects beyond the age of eighty are exempt from it. The middle lobe, as well as the two lateral, is often the seat of the disease; but the symptoms differ, in some respects, according as the former or latter happen to be affected. In proportion as the middle lobe enlarges, it pushes before it the internal membrane of the bladder, and by projecting into the cavity of that viscus, immediately behind the inner orifice of the urethra, obstructs the flow of urine; which, when the tumour, as it often does, attains considerable bulk, may be entirely suppressed. The enlarged lobe also, in many instances, becomes ulcerated, and gives rise to severe pain after passing urine, and to spasm about the neck of the bladder.

When an enlargement of one, or both, of the lateral lobes of the prostate is conjoined with that of the middle lobe, the symptoms are still more urgent. A discharge of a viscid, ropy mucus, is another attendant upon enlarged prostate, and a very common symptom of disease of the lateral lobes. The left lateral lobe is more frequently enlarged than the right. When the lateral lobes attain a considerable size, they project towards the rectum so as to diminish the capacity of that bowel, and may be distinctly felt by the finger per anum.

The *causes* of enlarged prostate are exceedingly obscure. By many the disease is attributed to syphilis, repeated attacks of gonorrhœa in early life, strictures of the urethra, inordinate indulgence with women, high living, intemperance, &c. But these inferences are rather gratuitous than founded upon any certain data.

Treatment of Enlarged Prostate.

The remedies for this disease are palliative only. Opium, internally administered, and in the form of enema, will prove highly serviceable in subduing spasm about the neck of the bladder, and thus enabling the patient to pass urine. Frequently, however, every effort of the kind will be unavailing, and the catheter must be employed. One of elastic gum, without the stilet, very flexible at the point, and of large size, will be found to give less pain, and enter with greater facility than a metallic instrument. It should be kept in the bladder for several days in succession, and after the urgent symptoms have somewhat subsided, introduced occasionally. In addition to this treatment, the use of mild purgatives, and attention to diet, will be required.

SECTION IV.

Retention and Incontinence of Urine.

FROM severe gonorrhœa, strictures in the urethra, enlargement of the prostate gland, spasm at the neck of the bladder, stone in the bladder, hemorrhoids, fistula in ano, rupture of the urethra, blows upon the perineum, stimulating diuretics, the application of blisters, injuries of the spine, paralysis of the bladder, stones in the urethra, and some other causes, a retention of urine frequently arises.

The disease, when it occurs amongst old people from paralysis, is not often followed by serious consequences, unless it should be mistaken for an *incontinence* of urine; a mistake which is apt, among the inexperienced, to arise from the circumstance of the urine constantly passing off by drops or in a small stream—one of the most decided symptoms of *retention*. Persons advanced in age are extremely apt to neglect the calls of nature, and suffer the urine to collect in the bladder in large quantity, or when they do make water are not particular enough in discharging the whole of it. From these and other causes, the bladder at last loses its power of expulsion, and the urine accumulates. As a part of it, however, is in general continually passing off by the urethra, that in the bladder seldom exceeds a certain quantity, and in this way the disease may be kept up for weeks together.

The retention which takes place in young people, from gonorrhœa, strictures, or any inflammation or excitement about the urethra, neck of the bladder, or neighbouring parts, is very different in its character, and often in its result, from that just spoken of. The urine seldom escapes, even in the smallest quantity, by the urethra, and must of course accumulate, (unless

the patient be relieved,) until some part of the bladder gives way—either by ulceration or sloughing. It is astonishing, however, to what an extent the bladder will yield in some cases before its parietes are destroyed. Some years ago I was called to a child about two years of age, supposed to labour under ascites, and so strongly did the enlargement and feel of the belly resemble that disease, that I at first took it to be a case of the kind. But, upon inquiring into the history of the complaint I ascertained that its duration had not exceeded seven days, and that during this period the patient had passed no urine. This induced me to examine the urethra, in the mouth of which I discovered a calculus that blocked up the passage completely. Upon enlarging the orifice with a lancet, the stone was instantly pushed out, and followed, to the surprise of a medical attendant and myself, and to the great relief of the patient, in a little time by two quarts of urine. Many instances are related by writers, of the bladder becoming so distended by urine, as to rise above the umbilicus; and Sir Everard Home relates an instance in which the celebrated Mr. Hunter actually tapped the bladder, mistaking the swelling for a dropsy of the belly. But such cases are anomalous; and in most instances, long before the bladder is distended to a great size, it ulcerates, or sloughs at the fundus or neck, and the urine is sent abroad into the peritoneum, or discharged through the rectum, or into the cellular membrane of the scrotum or perineum. In either event, the patient generally dies. During the progress of the distention the patient suffers exceedingly, grinds his teeth in agony, tosses about the bed, or walks his room with his body almost bent to the floor, is seized with chills, cold sweats and fainting, which are followed by fever, great restlessness, extreme thirst, intolerable anguish, swelling of the abdomen, hiccup, delirium, and death. He seldom survives beyond the sixth or seventh day.

Incontinence of urine is the reverse of retention. There are two or three varieties of the disease. Sometimes the urine passes off by the urethra as soon as it is secreted; at other times the patient can retain it for a certain period, and is then obliged suddenly to evacuate. In a third variety of the complaint, the discharge generally takes place during sleep. This is commonly confined to young children, while the other varieties are chief-

ly met with in adults, and are dependent for the most part upon general or local paralysis, general debility, injuries, malformation of the urinary organs, hemorrhoids, stone in the bladder, &c.

Treatment of Retention and Incontinence of Urine.

When retention of urine arises from stricture of the urethra, or from any inflammatory affection of the canal, or parts adjacent, blood-letting, the warm bath, purgatives, and opiate enemata, should have a full trial. If these fail, a gum elastic bougie may be carried down to the obstruction, and kept in contact with it a few seconds, after which, in many instances, the urine will flow. Should this, however, not produce the desired effect, the surgeon will then endeavour to introduce a catheter into the bladder. Than this, there is not, in all surgery, a more important, and, under certain circumstances, more difficult operation—an operation requiring the utmost gentleness, patience, perseverance, and skill. Rudeness and force, indeed, independently of the unnecessary pain and punishment they inflict, seldom contribute towards the end in view. It is true that some eminent surgeons, in difficult cases, advise the forcible entry of the catheter; but it should be remembered that a great majority of others, not inferior to them in authority, condemn the practice in the most pointed terms.

In general, the most favourable position for the easy introduction of the catheter, is the recumbent. But a good rule to observe on such occasions, is, if the surgeon does not succeed readily while the patient is in one position, to change it for another. The *curvature* of the instrument is also a matter of importance; on this account, the operator should be provided with a number, varying in shape and size. Gum elastic catheters, with or without the stilet, are better suited to most cases than metallic instruments. Sometimes, however, I have suc-

ceeded easily with a silver catheter, when a gum elastic would not enter. In using the latter, there is an advantage now and then obtained, especially when the middle lobe of the prostate is enlarged—in withdrawing the stilet an inch or two, so as to leave the extremity of the instrument more flexible than it otherwise would be. With the same view, Dr. Physick* has long been in the habit of using a gum elastic catheter, with a flexible wax bougie fixed upon its extremity. Stilets made of brass, instead of iron wire, are in many respects the most useful.

Having oiled the catheter, the surgeon takes hold of the glans penis, on its sides, immediately behind the corona, enters the instrument, with its concavity towards the abdomen, at the urethra, carries it along steadily, and with one continued sweep, (the penis being drawn upwards at the same time upon the instrument, and laid nearly parallel with the abdomen,) until it reaches the bulb or triangular ligament of the urethra. Here the passage takes a sudden turn upwards, and it will be necessary to accommodate the point of the catheter to the curve. With this intention, the handle of the instrument is suddenly, but cautiously and without force, depressed. This manœuvre elevates the point, and causes it to start over the edge of the triangular ligament, and enter the bladder. Should much difficulty be experienced, however, in this stage of the operation, it may be often overcome by placing a finger in the rectum, and with it, lifting the end of the catheter. Whenever an obstruction is met with in the urethra, which the catheter does not readily pass, instead of attempting to overcome it by force, it will be proper always to withdraw the instrument a little, elevate its point, and then push it on again.

In retention of urine from paralysis, the introduction of the catheter is seldom attended with difficulty, and on this account the operation may be repeated two or three times a day, or as often as may become necessary. But when the surgeon finds it inconvenient to attend for that purpose, a flexible catheter may be left in the bladder, for two or three days at a time, and the urine permitted to flow off, at stated periods, in place of dribbling away constantly. After the bladder has recovered its tone, the

* For a description and drawings of this instrument, see Dorsey's Surgery, vol. 2.

catheter should be discontinued. Having experienced considerable difficulty in introducing the catheter, in some obstinate cases of retention of urine, it occurred to me, in 1811, that the resistance might, perhaps, be overcome by introducing the pipe of a syringe into the orifice of the urethra, and throwing in gently a stream of tepid water. Having accordingly tried the plan successfully, in a few cases, I was induced to recommend the practice for several years, in my lectures. Subsequent experience, however, taught me that very little reliance could be placed upon the method, and I have since abandoned it altogether. *Amusat*, of France, has, within the last few years resorted to a similar expedient, and, according to his account, with great success.

If, in spite of the efforts of the surgeon to relieve the patient by the remedies pointed out, and it is found impossible to introduce the catheter, it will become necessary to *puncture* the bladder. The operation may be performed above the pubes, or through the rectum. But it will be proper to premise that neither one nor the other are indispensably necessary once in a hundred times.

The operation *above the pubes* is performed in the following way. The patient being laid upon a table, an incision, about an inch and a half long, is made in the linea alba, immediately above the pubes, through the integuments and fat, and between the pyramidales muscles, until the distended bladder is distinctly felt, when a curved trocar, six inches in length, covered by its cannula, is made to pierce the bladder as near the pubes as possible. A vessel being held between the patient's thighs to receive the urine, the stilet is withdrawn and the fluid evacuated. To prevent the cannula from slipping out, tapes are fastened to its wings, and secured to a bandage passed around the body. Its extremity is also plugged up, to prevent the perpetual flow of the urine. The greatest objection to this operation, is the liability of the urine to escape, (after the bladder becomes flaccid,) into the cavity of the abdomen. Besides this, the constant presence of the silver cannula is apt to excite irritation, especially when it is so long as to rest upon the back part of the bladder.

The puncture of the bladder, *through the rectum*, I should prefer, in every instance, provided the prostate was not so much

enlarged as to require the instrument to be introduced high up the intestine. To perform this operation, (which is still more simple than that above the pubes,) to advantage, the patient should be placed in the position for lithotomy, and the fore-finger of the left hand carried up the rectum, as a guide to the trocar, which is held in the right hand, introduced into the rectum, and made to perforate the anterior part of that intestine, at its centre, immediately above the prostate. The stilet being withdrawn, and the urine evacuated, the cannula is plugged, and secured in its situation by tapes. The patient's bowels should afterwards be kept in a soluble state, to prevent the cannula from being disturbed during an evacuation of the fæces. After the natural route through the urethra is restored, the cannula may be withdrawn, and the opening in the rectum allowed to heal. Whether the operation of puncturing the bladder be performed above the pubes, or through the rectum, it is very important that it should not be delayed beyond the *third* or *fourth* day; for it has been found by experience, that after this period, the case has usually terminated fatally.

For *incontinence* of urine, when it occurs in adults, and depends upon general or local debility, the internal use of cantharides, muriated tincture of iron, bark, and opium, conjoined with the cold bath, and blisters to the sacrum, will sometimes effect a cure. That variety of incontinence peculiar to children, gradually subsides spontaneously, as they advance in age. Parents, and children themselves, to guard against this infirmity, have sometimes, most improperly, applied ligatures to the penis over night. From this practice, there are numerous instances on record, of ulceration of the urethra, or of sloughing of the penis, at the part embraced by the ligature.

On Diseases of the Urethra and Prostate Gland, consult *Hunter on the Venereal*—*Home on the Treatment of Strictures of the Urethra and Œsophagus*, 3 vols. edit. 4.—*Whateley's Improved Method of Treating Strictures of the Urethra*, edit. 2.—*Letters concerning the Diseases of the Urethra*, by Charles Bell—*Principles of Surgery*, by John Bell, vol. 2, p. 209—*Howship's Practical Observations on Diseases of the Urinary Organs*, 1816—*Wilson's Lectures on the Structure and Physiology of the Male Urinary and Genital Organs, and their Diseases*, 1821—*Desault's Works*, by Smith—*C. Bell's Surgical Observations*, p. 86—*C. Bell on the Diseases of the Urethra*, &c. by J. Shaw—*Bingham on Strictures of the Urethra*,

1821—*Home on the Treatment of Diseases of the Prostate Gland*—*Hey's Practical Observations in Surgery*, article *Retention of Urine*, p. 388, edit. 3—*Dorsey's Surgery*, vol. 2—*C. Bell's Operative Surgery*, vol. 1—*Colles' Surgical Anatomy*, p. 159, article *Passing the Catheter*—*Abernethy on the Operation of Puncturing the Bladder*, in *Surgical Works*, vol. 2, p. 189—*Cooper's First Lines*, vol. 2, p. 215.

SECTION V.

Urinary Calculus.

MOST calculous concretions are formed originally in the kidney, and thence find their way, along the ureters, to the bladder, and when too large to pass off with the urine, remain in that viscus and serve as nuclei for other sabulous depositions. But any extraneous body, accidentally lodged in the bladder, may lay the foundation of a stone. A drop of blood, a portion of inspissated mucus, a pin, a piece of bougie or catheter, a musket ball, has often produced the disease. Many years ago, I operated on a boy four years old, and took from his bladder a stone, as large as a pullet's egg, in the centre of which was found the greater part of a needle.

Urinary calculi vary exceedingly in form, size, colour, consistence, and chemical composition. Some are very rough on the surface, others perfectly smooth; in shape most of them are oval, a few quite round, whilst others are oblong or angular. The difference in magnitude is not less remarkable—being met with from the size of a pea to that of a cocoa-nut. Calculi differ from each other in colour as much as in size and form; the most common variety is generally of a yellowish brown tint; some are nearly as white as chalk, and others, again, red or of a deep chocolate brown. In consistence, also, there is the utmost variation; for, at the slightest touch some crumble into dust, whilst others almost resist the stroke of a hammer. Scheele and Wollaston were among the first to investigate the chemical composition of urinary calculi, and their discoveries have led others to pursue the same path. According to the latest and best writers, these substances are found to consist of the following materials: 1st, of lithic acid, 2d, of the lithate of

ammonia; 3d, of the phosphate of magnesia and ammonia; 4th, of the phosphate of lime; 5th, of the oxalate of lime; 6th, of the triple phosphate of magnesia, ammonia and phosphate of lime; 7th, of the carbonate of lime. Of these the lithic acid calculi are by far the most numerous. A very uncommon variety of calculus has been met with, in this country, consisting of sabulous matter and *hair*, and resembling, closely, common plastering mortar. Only two instances of the kind have come to my knowledge. The first occurred about eighteen months ago, in the practice of Dr. Physick, and the second, within the same period, in that of my friend, Dr. Lemoyne, of Washington county, Pennsylvania. In both patients, the formation of this material was progressive, or kept up for months together.

Urinary calculi may be contained in the kidney, ureter, bladder, prostate gland, or urethra; but the bladder is their most common receptacle. Generally they lie loose within the cavity of that viscus, and at its most depending part. Sometimes they are contained in *cysts*, formed between the coats of the bladder at the termination of the ureters, or between the folds of a contracted bladder; at other times they are fixed upon a fungous excrescence, the granulations from which shoot into the interstices of a rough stone, and hold it fast. The bladder may contain a single stone, or a great number. Fifty-five were found in the bladder of the celebrated Buffon after death. Two hundred were taken by Desault, from the bladder of a priest. Sir Astley Cooper states that the greatest number he ever extracted, was one hundred and forty-two. Boerhaave and Beauchene, each record an instance of three hundred and upwards taken from different patients. Murat met with six hundred and seventy-eight. But the largest number ever removed, probably, from the human bladder, was taken by Dr. Physick, three or four years since, from Chief Justice Marshall. More than one thousand, varying from the size of a partridge shot to that of a bean, were counted, and many others were lost. They were all of an oval shape, and upon the end of each I examined, as it came out from the wound there was a black spot of the size of a pin's head. Notwithstanding the frequent introduction of the forceps and scoop, the patient recovered, perfectly, in a short time. When numerous, they are generally smooth upon their

surface, and sometimes, in particular places, highly polished, from continued friction upon each other.

The *symptoms* of stone must depend, in a great measure, upon the particular situation it happens to occupy. When detained in the pelvis or infundibulum of the *kidney*, the concretion sometimes attains a large size, without subjecting the patient to much pain or inconvenience; on the other hand, its presence is occasionally productive of so much irritation as to excite suppuration of that gland. During the passage of a calculus along the ureter, the patient suffers in most instances excruciating pain, has a frequent desire to make water, and can pass only a few drops at a time, and that very high-coloured and sometimes mixed with blood. So severe is the pain in some cases, that the patient finds it impossible to leave his bed, and is obliged, in order to obtain temporary relief, to bend himself almost double. Fever, eructation, nausea, vomiting, and spasmodic retraction of the testicle, are common accompaniments of the disease. As soon as the stone drops into the bladder, the symptoms subside. Sometimes, however, the patient becomes easy for a few hours, even before the stone leaves the ureter, and then has a relapse. This may occur repeatedly.

An *encysted* stone, so long as it continues encysted, seldom gives rise to any severe symptoms; but a stone that lies loose in the bladder, and is liable to move about, must always excite more or less uneasiness, whether it be rough or smooth, large or small. One of the first symptoms of stone in the bladder, is a frequent desire to pass urine, and severe pain upon voiding the last drops of it. About the same period, also, the patient complains of an itching at the glans penis, to relieve which, he soon gets into the habit of pulling or elongating the prepuce. Another symptom, is the sudden stoppage of the urine while passing in a full stream. This arises from the stone being carried, by the contraction of the bladder, or by the stream of urine, to the neck of the bladder, where it blocks up the inner orifice of the urethra; in proof of which, if the patient lie down or change his position, the water flows again. After these symptoms have continued for some time, the patient becomes troubled with tenesmus and prolapsus ani, induced by the constant straining and efforts to empty the bladder. When the stone is rough on its surface, there is often a good deal of mucus discharged

along with the urine, which is now and then mixed with blood. Sometimes the patient is very sensible, when he turns upon his side, or suddenly changes his position, of something rolling in his bladder. The same sensation is experienced whilst on horseback, or in a carriage. Under the sufferings occasioned by the symptoms enumerated, the patient may live for a great number of years. Gradually, however, his health declines, the bladder contracts to a very small size, becomes thickened and diseased, and at last death takes place from long-continued irritation and derangement of most of the bodily functions.

When the *prostate gland* contains a number of stones, it may be possible to feel them through the coats of the rectum, by passing the finger within the gut. Dr. Marcet mentions a case in which Sir Astley Cooper was able, by this expedient, to detect a number of calculi moving in a cyst within the prostate, and to hear a distinct clashing as their surfaces were pressed together.* Calculi, when detained in the *urethra*, generally stop behind the bulb, or at the external orifice of the passage. From being pressed upon by the stream of urine, they are sometimes imbedded in the substance of the penis, and afterwards do not obstruct the urethra.

The *causes* of the formation of urinary calculi, although frequent attempts have been made to investigate them, have never been unravalled. We know, indeed, little beyond this,—that the disease prevails in certain countries and districts, more than in others, and that in some climates, especially very warm ones, it is never met with. Throughout the United States, which embrace a very extensive tract of country, fugitive cases may be every where seen; but, upon the whole, the complaint must be considered by no means common, if we except some portions of the western country, especially Kentucky, Alabama and Tennessee, where it is exceedingly frequent, and usually attributed, though, perhaps, erroneously, to the use of lime-stone water.

* Marcet on Calculous Disorders, p. 19.

Treatment of Urinary Calculus.

When a patient is suffering from a fit of the gravel, as it is usually called, or in other words, from the passage of a calculus along the ureter, the most decisive treatment must be at once adopted. If robust and vigorous, several ounces of blood may be taken from the arm, and a brisk purge administered immediately afterwards. These should be followed by immersion of the whole body in a warm bath. If, by these means, the pain is not diminished, ten or fifteen drops of spirit of turpentine may be given, three or four times a day. This remedy has been used by Dr. Physick, for many years, with the greatest success. A combination of turpentine and opium, according to Dr. Marcet, was formerly employed, as a quack medicine, in England, with great benefit in this complaint. By the advice of Dr. Physick, I prescribed, some years ago, the tincture of *phytolaca* (pokeberry) in an obstinate case of lithiasis, and with the most decided relief to the patient. It should be administered in doses of a dessert spoonful two or three times a day. Sometimes I have known the patient much relieved by suddenly throwing up the rectum a stimulating enema. Opiate injections, also, in some cases, prove highly beneficial.

The existence of a stone in the bladder, can only be determined, positively, by sounding. This preliminary operation should, therefore, always be performed before the surgeon enters upon the treatment of the disease. By sounding is meant the introduction of a steel instrument, resembling a catheter, (but solid, instead of hollow,) into the bladder. The rules formerly pointed out for the management of that instrument, in cases of retention of urine, should also be observed in the introduction of the sound. Very often the stone cannot be felt, in consequence of its lodging in a depending part of the bladder, below the reach of the instrument. In such cases the finger is put into the rectum and the lower part of the bladder pressed upwards, and the stone being carried by this manœuvre along with it, rubs against the instrument. Or, the urine may be permitted to accumulate in large quantity, and the walls of

the bladder being then distended, the stone will be raised from its lurking place and touched by the sound. But this expedient sometimes fails: in that event, the practice first pointed out by Dr. Physick should be pursued—by placing the patient “nearly on his head,” so as to render the fundus of the bladder the lowest part, and thus bring the stone in contact with the point of the sound. The surgeon should take care not to mistake a stone in the urethra, or prostate gland, for one in the bladder. He must particularly remember, moreover, never to sound a patient during a fit of the stone, or immediately after his arrival from a journey. Having ascertained that the bladder contains a stone, its removal should next be determined upon. But, before this is resorted to, the surgeon must endeavour to mitigate the symptoms as much as possible, or, in other words, to prepare the patient for the operation. Formerly, many attempts were made to destroy a stone, either by the use of internal medicines, or by the injection of fluids into the bladder. The practice, however, has long been abandoned—having been found ineffectual. But in another point of view it has proved highly useful—by relieving the symptoms, and thereby rendering the patient’s chance of recovery after an operation more certain. The best medicines, for this purpose, in most cases, are the alkalies, especially in the form of soda water, or the carbonate of soda. Magnesia, also, has often proved very serviceable. Together with this treatment, the patient should be obliged, for two or three weeks before the operation, to live on a low diet, and take occasional purgatives. The operation should not, if it can be avoided, be performed during very warm, or very cold weather. A few hours previous to the operation, the rectum should be emptied by an enema, the perineum shaved and a tape tied round the patient’s penis to prevent him from making water. The latter is so important, that to ensure its observance, a careful attendant should watch the patient from the time the penis is tied, until the operation. Various modes of performing lithotomy have been practised from time immemorial; but it is merely my intention in this place to describe the lateral operation as it is performed at the present day by the most eminent surgeons—with the *gorget*.

The *instruments* are two or three scalpels, a curved probe-pointed bistoury, a straight sharp-pointed bistoury, a staff with

a large deep grove, Physick's gorget,* several forceps, smaller than they are usually made, a scoop, tenacula, ligatures, sponges, a curved needle and forceps for the pudic artery, a large pewter injecting syringe with a pipe six inches long, tepid barley water carefully strained, strong bands of woollen or muslin, two inches broad and three or four yards long, and a bowl of warm oil.

A narrow dining-table is selected and the leaves turned down. Over the table is placed a thick blanket, several times folded. On this the patient, dressed merely in a shirt and loose night gown, is laid—with a pillow under his head, his pelvis resting on the lower edge of the table, and his legs and thighs supported by an assistant, on each side. The surgeon unties the penis, dips his staff in warm oil, introduces it into the bladder, and having satisfied himself, and the other medical attendants, of the presence of a stone, gives the staff to a third assistant, with an injunction not to let its point slip from the bladder. He then passes each wrist through loops formed at the extremities of the bands or fillets, directs the patient to grasp the soles of his feet, and fastens them and the hands together by numerous turns of the bandage. The assistant, holding the staff steadily with one hand, and standing on the side of the patient, is then directed to raise and support the scrotum and testicles with the other hand—taking especial care that the end of the staff is fairly within the bladder. The assistants, appointed to secure the patient's limbs, must each place a knee in their armpit, grasp a foot with their hands, and sustain the thighs nearly in a perpendicular position, separating them, at the same time, moderately. The surgeon then seats himself before the patient on a low stool, (having previously arranged his instruments in the order he will require them, on a small table placed within his reach, takes a scalpel of moderate size, makes an incision in the left side of the perineum, commencing a little below the arch of the pubes, extending downwards, with a slight obliquity, between the rectum and tuberosity of the ischium, and terminating

* This instrument differs from the common gorget in having a moveable blade, or one that can be separated from the back, for the purpose of sharpening it to greater advantage. For a particular description of it, see Dorsey's Surgery, vol. 2d.

opposite the lower margin of the anus. This first cut is made, not with the point of the knife, but with its convex edge, through the integuments, fat, and perinæal fascia. By repeated strokes of the knife, the transversales muscles are next unbridled, and the membranous part of the urethra and prostate gland laid bare. At this stage of the dissection, the operator will sometimes find it necessary to stop and take up the transversalis perinæi artery.* The membranous part of the urethra and staff being distinctly felt by the fore-finger of the left hand, the surgeon next takes the *sharp-pointed* bistoury, carries it to the bottom of the wound, with its back towards the rectum, and opens the membranous part of the urethra, to the extent of half an inch or more, by cutting from behind forwards, or from the prostate towards the bulb. As soon as the urethra is opened, a stream of urine, (provided the patient has retained it,) issues through the wound. Without loss of time the surgeon next lifts the gorget, fixes its beak in the groove of the staff, takes the handle of the staff from the assistant, depresses it, balances for a moment the two instruments on each other, runs the beak of the gorget backwards and forwards, two or three times, to be certain that it is fairly in the gutter of the staff, then with a slow but steady and decided movement carries the instrument onwards to the bladder through the prostate gland. A sudden and impetuous gush of urine announces the completion of this stage of the operation. The gorget being withdrawn, the left fore-finger of the operator is immediately introduced, the stone felt, and the staff taken away. Still keeping the finger in the bladder the surgeon then takes a small pair of forceps, and with the blades shut, carries the instrument through the opening in the prostate, alongside the finger, touches the stone, removes the finger, expands the blades of the forceps, seizes the stone, (gently, lest it break,) parallel, if possible, with its longest diameter, and gradually extracts it. As soon as it is removed, an accurate examination should be instituted, in order to discover whether there be any other stones left behind. If so, the forceps must be again and again introduced, until the whole are extracted. To clear the bladder of any fragments, sand, or clotted blood, that may happen to remain, the pipe of the syringe

* Usually this vessel does not require the ligature.

should be introduced, and a quantity of tepid barley water thrown in, repeatedly, until the bladder is completely rinsed out. Any vessel of importance, that may happen to have been cut will probably continue to bleed after the stone has been extracted and should be secured by ligature without delay. If the pudic artery is divided by the knife or gorget, it will pour out blood copiously, and from this cause many patients have lost their lives. The forceps and needle* used by Dr. Physick, for deep-seated arteries, will be found the best instrument for taking it up.† As soon as the hemorrhage has stopped, a gum elastic catheter, of large size, should be carried through the wound into the bladder, the bandage removed from the hands and feet, and the patient laid in bed on his left side—the thighs being lightly bound to each other, by two or three turns of the roller. The gum elastic catheter, projecting from the wound serves to carry off the urine, which being received in a dish, the patient is kept constantly dry and comfortable. For several days the urine continues to pass by the perineum; at length, however, it is discharged through the penis, and very little runs through the wound. The catheter should then be removed, and, in a short time, the opening in the perineum will heal. In a few rare instances, indeed, the incisions have healed by the first intention; but in general, three or four weeks elapse before a cure is effected.

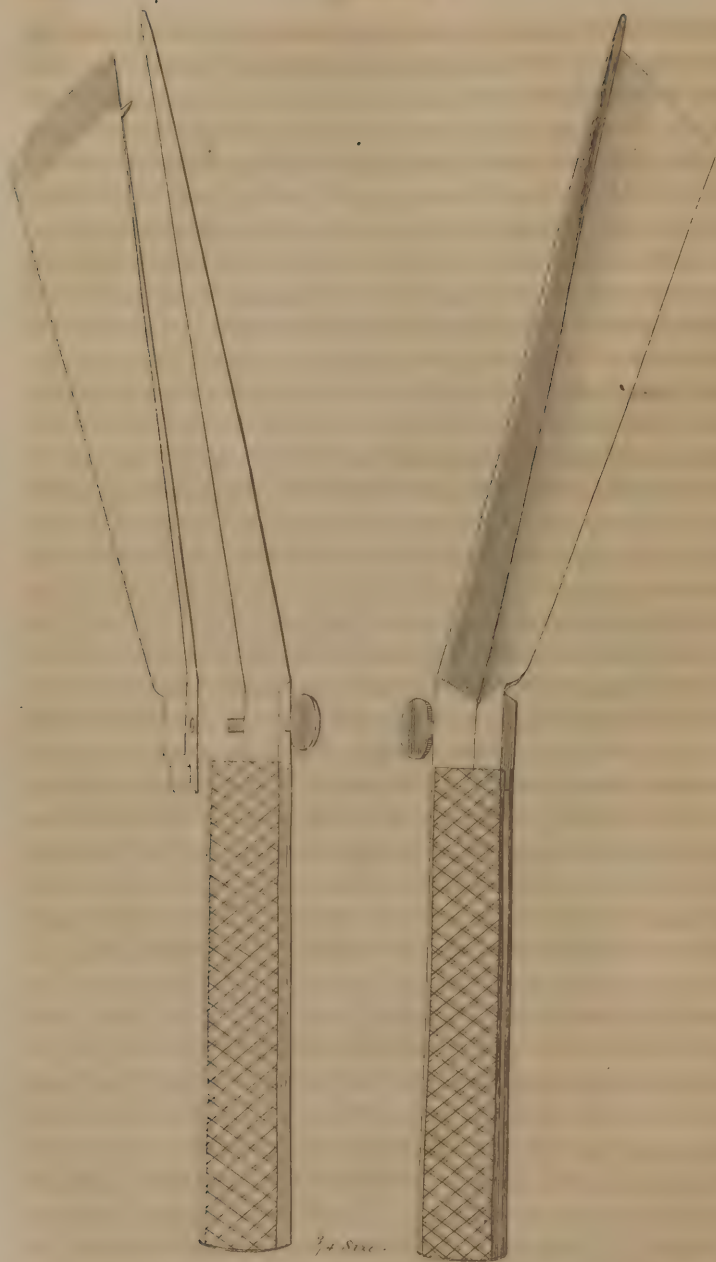
* See vol. 1st, p. 55.

† It sometimes happens that after the stone has been removed, and the patient put to bed, secondary hemorrhage takes place, and that the blood finds its way into the bladder, where it excites so much irritation as to cause a contraction of that viscus, and a sudden discharge of urine and coagulated blood through the wound. In fifteen or twenty minutes the same accumulation and expulsion again take place, and may continue until the patient is exhausted, unless the surgeon understands the nature of the accident and the mode of treating it. In all such cases, I have reason to believe, from what I have seen, that the hemorrhage proceeds from the *venæ vesicales*, or from some of the arteries above the prostate. Under these circumstances, a very ingenious mode of arresting the flow of blood was executed many years ago by Dr. Physick, (in the case of a Dr. B.) by introducing a large gum elastic catheter into the bladder through the urethra, and at the same time a long slip of lint between the lips of the prostate, so as to keep them in accurate apposition. The flow of blood being thus stopped, and the urine passing off by the catheter, instead of flowing through the wound, it follows that the hemorrhage will not return, so long as the lint retains its position, that it is important that it should be left for several days, or until suppuration takes place. By adopting this plan I have saved the lives of two patients, who otherwise, I am sure, must have perished.

The operation of lithotomy, as I have described it, must be understood as adapted to the adult, and as calculated for cases unattended with difficulty. The same rules should be observed, in performing the operation on infants and children—the instruments and incisions, in such cases, being proportionally smaller. In such subjects, moreover, the surgeon may expect to experience some trouble, from a frequent protrusion of the rectum, during the operation, inasmuch as most children, afflicted with the stone, are subject to prolapsus ani. Upon the whole, however, the operation of lithotomy in children is, compared with that of the adult, attended with few difficulties.

To guard against accidents, and to prepare the young surgeon for difficulties, which, at some period or other, he may expect to encounter, the following mementos should be carefully attended to.

1st. To examine *minutely* every instrument, before it is used, especially the gorget and staff. If the cutting edge of the former be not extremely sharp, it will not divide the prostate gland, but pushing it forward, will pass between the bladder and rectum, and deceive the surgeon, who, supposing that he has opened the bladder, thrusts the forceps into the wound, makes fruitless efforts to extract the stone, and, perhaps, may tear away, as has happened, the prostate and part of the bladder. If the gorget be not accurately fitted to the staff, it may be discovered, during the operation, (and at the critical moment of pushing the instrument into the bladder,) that the beak is too large for the groove. Under these circumstances, should the operator persevere in his attempts to thrust the gorget home, great mischief may ensue. The *size* of the gorget must always be proportioned to the age and size of the patient. A gorget, for an adult, should never exceed in breadth three-quarters of an inch, and, for most patients, one five-eighths of an inch will answer. Children seldom require an instrument beyond three-eighths of an inch in width. An unusually wide gorget always endangers the pudic artery. The most experienced lithotomists, however, of modern times, have always inculcated, and, as I conceive, justly, a free incision of the prostate and neck of the bladder, rather than tear these parts, in attempting to get out a large stone. How then can this be accomplished unless a *broad* gorget be employed? The answer is very easy. The chief



object of the gorget is to make an opening into the bladder; if this opening is sufficiently large to admit the finger of the surgeon and enable him to touch the stone, this is all he can require. Finding, by the feel, the stone too large to come away through the track made by the gorget, the *curved probe-pointed bistoury* is at hand, and with this the wound may be instantly enlarged to the requisite extent, and without exposing the pudic artery. In running the gorget along the staff, through the prostate and bladder, care should be taken to *depress* its handle, in order that the blade may be sufficiently elevated to pass in a line corresponding with the axis of the pelvis. This the operator sometimes finds it difficult to accomplish, owing to the blade of the gorget being made as broad near the handle of the instrument as at its point, and, on this account, not calculated to rest in the lower angle of the incision. To obviate this difficulty, I have, for several years past, had the blades of gorgets so constructed, as gradually to taper from the outer corner of the cutting edge to the handle of the instrument. See *Plate IV. fig. 1 and 2.*

2d. If the surgeon, from timidity, or any other cause, does not make his incisions in the perineum ample, but leaves some of the fibres of the transversales perinæi muscles uncut, he will find, in attempting to extract the stone, great resistance, and a constant tendency in it to slip from the grasp of the forceps. This resistance usually arises from the fibres of the transversalis perinæi alter. In such a case the fore-finger of the left hand should be carried towards the bottom of the wound to depress the rectum, while the remaining obstruction is removed by the knife. A wound of the rectum will not prove so serious an accident as some have represented; but, nevertheless, it should be carefully avoided.

3d. The lithotomy forceps are, in general, made unnecessarily large and clumsy; so large, indeed, as often of themselves to fill up the opening through the prostate. The teeth, too, on the inner surface of the blades, are often so large as to act like wedges, and break the stone the moment it is grasped. For a child, a forceps very little larger than the common pocket case instrument, will serve a better purpose than the one usually employed; and the smallest forceps contained in the lithotomy case, provided the handles be somewhat lengthened, will an-

swer for an adult.* If a stone should be so large as to require breaking, a strong pair of forceps, with a screw in the handles, will prove more effectual than the complicated instrument of Mr. Henry Earle. Although I have had occasion, however, in three instances, to break large stones, I have never experienced any difficulty in effecting it with the common forceps. Frequently, a stone will break under very moderate pressure of the forceps, and when the surgeon is unwilling for it so to do. In this event, great patience and gentleness must be exercised in extracting the fragments by the scoop, and by injections of barley water. It sometimes happens that one portion of a stone is imbedded in a cyst in the coats of the bladder, while the other projects into its cavity. This happened in a case, upon which I operated, at Alexandria, under the care of two distinguished physicians of that place—Drs. Washington and Sims. Having seized the stone with the forceps, the projecting half broke off, and the remainder, with great difficulty, I was obliged to scoop out of the cyst with my finger. The patient had long suffered from the disease, was greatly exhausted before the operation, and died ten or twelve days after it. Some years ago, I operated on a young man in the Alms-House Infirmary, and took from his bladder a stone about the size of a walnut, and afterwards introduced my finger to ascertain if there were any others left, when, to my great surprise, I discovered that the fundus of the bladder, for a considerable extent, was incrustated with calculous matter, which I peeled off in successive layers, some of which were nearly half an inch thick. This patient perfectly recovered. Under circumstances such as I have detailed, the surgeon should never, for a moment, lose his self-possession, but proceed cautiously and gently, but firmly, until he has effected his purpose. In the common operation of lithotomy, too, it should never be necessary to pull violently with the forceps, but the instrument must be humoured, and its position changed, and twisted gently in a variety of directions.

4th. The *after treatment* of lithotomy is oftentimes more important than the operation itself; and the surgeon would do

* Dr. John Rhea Barton, of this city, has invented a pair of lithotomy forceps, (with an oval hole in each blade, resembling the midwifery forceps, and not unlike the old polypus forceps of Heister,) well calculated, it appears to me, to hold a small stone, and prevent it from slipping.

well never to operate, unless he could attend the patient throughout the whole course of his confinement. I have now performed the operation of lithotomy upwards of forty times, and have lost out of that number, only six patients. My success, I attribute, in a great measure, to ample incisions, and to extraordinary care during the after treatment. Three out of the six patients died at a distance where I could not attend them, and the other three were greatly exhausted by the disease before the operation was performed. The shock communicated to the system by the severity of the operation, is sometimes such as greatly to endanger the patient's life, and, indeed, some have actually died on the table, or a few hours after—reaction having never been established. So long as this state of the system continues, stimulants, particularly ammonia, must be employed. After reaction takes place, then inflammation must be guarded against, and to prevent this, the antiphlogistic system, to the necessary extent, will be naturally resorted to.

The *high operation* of lithotomy, or that above the pubes, an account of which, it is said, was first given by Franco, in 1556, was formerly much practised, particularly by Frere Côme, Douglass, and Chesselden. The unfortunate termination, however, of numerous cases, caused it to be abandoned almost entirely. Still it has been revived at different periods, and latterly, by Souberbielle, of Paris, and Carpue, and Sir Everard Home, of London. But, even under the most favourable circumstances, it is an operation greatly inferior to the *lateral*, and, indeed, should only be practised, I conceive, in cases where the stone is ascertained to be of extraordinary magnitude, or where the prostate gland is very much enlarged. The principal objections to the operation arise from the difficulty of preventing the escape of the urine into the cavity of the pelvis, and the danger of wounding the peritoneum. If the operation be determined on, I should prefer the mode of executing it devised by Sir Everard Home, and as described by him in the following case.

“An incision was made in the direction of the linea alba, between the pyramidales muscles, beginning at the pubes, and extending four inches in length: it was continued down to the tendon. The linea alba was then pierced close to the pubes, and divided by a probe-pointed bistoury to the extent of three

inches. The pyramidales muscles had a portion of their origin at the symphysis pubis detached to make room. When the finger was passed down under the linea alba, the fundus of the bladder was felt covered with loose, fatty, cellular membrane. A silver catheter, open at the end, was now passed along the urethra into the bladder, and, when the point was felt by the finger in the wound, pressing up the fundus, a stilet, that had been concealed, was forced through the coats of the bladder, and followed by the end of the catheter. The stilet was then withdrawn, and the opening, through the fundus of the bladder, enlarged towards the pubes, by a probe-pointed bistoury sufficiently to admit two fingers, and then the catheter was withdrawn. The fundus of the bladder was held up by one finger, and the stone examined by the fore-finger of the right hand. A pair of forceps, with a net attached, was passed down into the bladder, and the stone directed into it by the finger: the surface being very rough, the stone stuck upon the opening of the forceps, and being retained there by the finger, was extracted. A slip of linen had one end introduced into the bladder, and the other was left hanging out of the wound, the edges of which were brought together by adhesive plaster. A flexible gum catheter, without the stilet, was passed into the bladder, by the urethra, and kept there by an elastic retainer surrounding the penis. The patient was put to bed, and laid upon his side, in which position the urine escaped freely through the catheter."

Some years ago, I was called to Virginia, to operate for lithotomy. I found the patient very far advanced in years, and labouring not only under stone, but morbid enlargement of the middle and lateral lobes of the prostate. Knowing the difficulties I should have to contend with under these circumstances, I determined, instead of performing the *lateral* operation, to open the bladder above the pubes. Accordingly, assisted by Drs. Withers and James, two eminent practitioners of the neighbourhood in which the patient resided, I performed the operation after the manner of Sir Everard Home above described, and succeeded without difficulty in removing two calculi. The patient's chance of recovery, notwithstanding his age and the enlargement of the prostate was very favourable; so much so, that feeling himself, as he imagined, perfectly secure, and tired

of restraint and confinement to bed, he insisted upon the catheter being withdrawn, (contrary to very strict injunctions I had left with him,) and in consequence soon after perished from peritoneal inflammation induced by effusion of urine into the cavity of the pelvis. This was the first instance, I believe, in which the *high* operation had been performed in America. It has since been done, successfully, by Dr. Carpenter, an eminent physician of Lancaster, and also, as I understand, by Dr. Van Volsy, of Lewisburg, Union county, Pennsylvania.

Females are subject to calculus as well as males, though the disease in the former is by no means so frequent as in the latter—owing to the female urethra being so short and large as readily to permit the escape of the calculous particles before they become so large as to form a stone. The *symptoms* created by the presence of a stone in the female bladder resemble those which have already been pointed out as characterizing the disease in males; in general, however, women suffer more than men from the disease.

There are two modes of extracting the stone from the female bladder—by *dilatation* of the meatus urinarius, and by *incision*. The former was often practised by the older surgeons, and within the last twenty or thirty years, has been occasionally resorted to. It should be preferred, in general, to the knife, (especially when the stone is small,) inasmuch as it is not so liable to be followed by *incontinence* of urine. A bit of compressed sponge, or wax bougies gradually increased in size, will answer very well to dilate the passage with. When the stone is found to be very large, it will, perhaps, become necessary to divide the urethra, and the best mode of performing the operation, is, I think, the following. The patient is placed in the ordinary position for lithotomy, and her hands secured to the feet by bandages. The surgeon then introduces into the urethra a straight staff, with its groove directed towards the left ischium, and holding it firmly by the handle, passes with the right hand a straight bistoury through the urethra and neck of the bladder, obliquely downwards. The finger being introduced and the stone felt, it may be readily removed with the straight or curved forceps. As incontinence of urine has followed in all the cases in which Sir Astley Cooper has performed or witnessed the

operation, he has expressed his determination, in future, to try the effect of a suture upon the edges of the wound.

Carpue's History of the High Operation, &c. 1819—*Sanson des Moyens de Parvenir a la Vessie par le Rectum*, 1817—*Dictionnaire des Sciences Medicales*, tom. 28, p. 422—*Traité Historique et Dogmatique de l'Operation de la Taille*, par J. F. L. Deschamps, Paris, 1796, 4 tomes, 8vo.—*John Bell's Principles of Surgery*, vol. 2, part 1—*Desault's Works*, by Smith, vol. 3—*C. Bell's Operative Surgery*, vol. 1, p. 329—*Earl's Practical Observations on the Operation for the Stone*, 1803—*Roux's Journey to London*—*Allan's Treatise on Lithotomy*, 1808—*Colles' Treatise on Surgical Anatomy*, p. 145 and 169—*Cooper's First Lines of the Practice of Surgery*, vol. 2, p. 320, edit. 4—*Dorsey's Surgery*, vol. 2—*Dorsey's Inaugural Essay on the Lithontriptic Virtues of the Gastric Liquor*, 1802—*Marcel's Essay on the Chemical History and Medical Treatment of Calculous Disorders*—*Prout's Inquiry into the Nature and Treatment of Gravel, Calculous, &c.*—*Magendie on Gravel, &c.*—*Wilson on the Urinary and Genital Organs*, London, 1821, 8vo.

SECTION VI.

Lithotrity.

AMONG the obsolete and musty records of ancient times, isolated scraps of valuable matter, plausible hints and speculations, ingenious instruments and operations are met with as “*rari nantes in gurgite vasto.*” By the industry, however, of such men as Ploucquet, Sprengel, Good, Young, S. Cooper, and a host of German labourers, the golden sand has long been washed and picked from the rubbish which surrounded it, and whether dug from the caverns of Pompeii or Herculaneum, or collected from the deserts of Egypt or Arabia, or scraped from the ruins of Greece, has been preserved pure and unalloyed, and stored up for its rightful owners. But how few and unmerited are the claims of the ancients to those treasures which have been so unsparingly showered for the last fifty years upon every department of the healing art. And yet, no sooner is a discovery made, or a new idea started, or a new operation performed, but the claim to priority is contested by a bold assertion that Hippocrates, Galen, or Celsus, or some other antediluvian, is entitled to the honour of the claim in question. This disposition to detract from well-merited fame, every where so prevalent, and inherent, perhaps, in human nature, was strikingly displayed a few years since in France, in relation to the operation of *Lithotrity*; for when Civiale, a poor and obscure, but most meritorious and ingenious individual, demonstrated that the stone could be destroyed in the human bladder, and removed, without the operation of lithotomy, it was immediately proclaimed that there was nothing *new* about the affair, that he deserved no credit for the operation; for that a monk of Citeaux, and Martin, an English colonel, had both relieved themselves, long before, by

nearly the same means; that Gruithseisen, a Bavarian physician, had made similar experiments, and that even Ammon of Alexandria, Franco, Ambrose Parey, Hildanus, Sanctorius, Germanus, and Haller, were acquainted with lithotrity, that Amusat, Leroy and others, were all familiar, before Civiale, with the operation.

But, in answer to all this, it may be said, (admitting that some obscure hints might have been thrown out, or nugatory experiments made by the individuals mentioned, or others,) that no brilliant discovery, or invention, ever was made, perhaps, that had not been previously imagined or thought of by some one, and that the man who, while struggling with poverty and almost overwhelmed with difficulties of every description, has energy enough to bear up and to persevere for years amidst privations and sufferings, and, finally, to bring triumphantly his experiments to successful issue, and adapt them to *practice*, is entitled fairly to the chief glory of a discoverer. To whom but Fulton are we really indebted for steam navigation? To whom but Civiale do we actually owe the operation of lithotrity? It is natural for us to look, in this age of project and trickery, with distrust towards proposals not sanctioned by long experience, and there were many, accordingly, disposed to undervalue the labours of Civiale. For myself, I candidly own, that for years I had no faith in the operation, as regards the full advantage to be derived from it, and the facility of executing it, and believed, with many others, that it was adapted only to extraordinary cases. From the first, however, I never hesitated to speak of it, both in this work and my lectures, as a "most ingenious and beautiful idea," and to say, that the time would probably come, when the operation would be so modified and improved, as to deserve all the praises then so inconsiderately lavished upon it. At the same time, the young surgeon was cautioned how he ventured to undertake the operation, (which from trials, made by some of the most skilful surgeons in this country, was found to be extremely difficult, delicate and dangerous,) under the idea, then too prevalent, that any one of ordinary capacity and practice could perform it. That the advice I then gave was just, and such as ought to have been followed, experience has since proved; for although there are now many successful operators in Europe, and a few in this country,

every one of them, I am sure, will acknowledge that lithotrity requires a tact, an attention to minute circumstances, a discrimination rarely possessed, and above all *instruments* which not one cutler in a thousand can manufacture. Upon the whole, then, it may be stated, that lithotrity has become an *established* operation, that it is adapted to a greater number of cases than was, originally, supposed possible, that in the hands of skilful operators it is generally safe, if not successful, and that when the patients are healthy, middle-aged, or advanced in years, the urethra large and free from disease, the stone small and soft, and when females are the subjects of it, the operation should always be attempted in preference to *lithotomy*. On the other hand, it must be remarked, that it is seldom adapted to children, or to very irritable and diseased patients, or to cases where the stone is large and extremely hard.

Before describing lithotrity, it will be necessary to give an account of the instruments employed in the operation. I have already remarked that these are extremely difficult to make. Thoroughly convinced of this, I ordered a set from Paris, of the finest finish and construction, which, through the kindness of M. Civiale, were made under his own eye and direction, and every one examined by him and altered, until it met his approbation. Such of these, only, as are *essential* in the operation I shall describe in this place. There are many instruments invented by Heurteloup, Leroy and other lithotritists, that possess no advantages, I conceive, over Civiale's, and which, therefore, need not be noticed in a work of this description.

Civiale's apparatus, or lithontripteur, consists, 1st, of a silver cannula eleven inches long, and from two to four lines in diameter, open at its lower extremity and having at its upper a circular rim, connected with an oblong shoulder, intended to secure the cannula in a corresponding handle, or lathe, to be afterwards described. Attached to this extremity, likewise, is a cylinder of leather enclosed in a circular box, to render the cannula watertight. 2dly, of a steel cannula, longer than the silver one, made to fit and work on the inside of it, having at its lower end three elastic branches which curve inwards, are rounded at their extremities, are intended to seize the stone, and are so contrived as, when drawn within the outer cannula, to pack closely together and form a smooth rounded end, well calculated to glide

along the urethra and enter the bladder. The upper extremity of this cannula is numbered, or graduated, to enable the operator to ascertain the degree of expansion of the *litholabe* or claw, and is connected by a screw, to a rim or circular box filled with leather, somewhat similar to the one on the silver cannula, and intended for the same purpose—to prevent the escape of fluid during the operation. Sometimes *four* pincers, or claws, are used instead of three; and in certain cases, two only are employed. But Civiale has found *three* the most convenient, in the generality of cases. 3dly, of the *lithotriteur*, or perforator,—which is a steel rod, six inches longer than the litholabe, having upon one extremity a crown with a number of cutting edges, or teeth, calculated to pulverize, or grind the stone, or reduce it to fragments, and upon the other a graduated scale intended to denote the size of the stone within the grasp of the claw. This extremity is rounded, and, for half an inch beyond the scale, is slightly serrated, or ragged, in order that it may be securely held in the jaws of a grooved pulley designed to communicate to the lithotriteur a rotatory motion, when passed through the cannula of the litholabe. 4thly, of a brass frame, or lathe, somewhat similar to that used by watchmakers, the curved extremity of which has a square cavity, with lateral grooves on its interior, intended to receive the corresponding oblong shoulder of the silver cannula and to be secured in it by a screw; while the other extremity, or straight square shank of the lathe, is designed as a bar upon which a popet head slides backwards and forwards. Parallel with the bar, and fixed upon the superior extremity of the popet head, is a cylindrical brass tube, which encloses a spiral spring connected with a steel pivot, the cup-like extremity of which receives the rounded end of the *lithotriteur*, and, by the operation of the spring keeps its dentated crown in perpetual contact with the stone. This lathe, during the operation, is held by the hands of an assistant. 5thly, a steel drill bow, about twenty-five inches long, jointed in the centre, firm but elastic, and well tempered, fixed in an ivory handle, and mounted with catgut, is designed to play upon the pulley connected with the lithotriteur, and may be said to complete the apparatus. Three, or four, sets of the external cannula, and litholabe, of different sizes, and a proportionate number of the lithotriteur, (ten or fifteen,) should accompany each case of instruments.

The patient having been sounded, the presence of a stone detected, the state of the health inquired into, the condition of the bladder, the size, consistence and situation, as far as practicable, of the stone ascertained, and lithotrity determined upon, the first step is to enlarge the urethra, *gradually*, by the introduction of bougies, sounds, or catheters, commencing with small instruments, successively increasing their size, and suffering each to remain in the urethra ten or fifteen minutes at a time. This practice having been pursued for eight or ten days, the urethra, besides being dilated, becomes accustomed to instruments, and its natural sensibility thereby diminished. Some operators, however, and among them Leroy and Bancal, deem the preparatory treatment unnecessary; but by Civiale it is considered, generally, indispensable.

Immediately before commencing the operation, the bladder is explored by the sound, a second time, and the stone being felt and appearing not too large to be embraced by the litholabe, the patient is laid on a bed and his hips elevated by bolsters, in order to make the stone gravitate towards the fundus of the bladder. A common catheter is then carried into the bladder, and the pipe of a syringe being adapted to its extremity, projecting from the urethra, tepid water, or strained barley water, is injected until the patient complains of a disposition to urinate. The catheter is then withdrawn and the lithontripteur, (with the branches of the litholabe retracted within the cannula, and all other parts of the instrument accurately adjusted,) well greased, is introduced into the urethra by the right hand—while the penis is depressed by the left, parallel with the thighs, which are slightly flexed. The instrument passes readily until it arrives at the bulb of the urethra; it then meets with resistance, which is only to be overcome by depressing the external portion of the lithontripteur, and elevating its point, which starts forward, glides along the membranous portion of the urethra and prostate, and enters the bladder. The stone is then searched for, and, in general, may be felt distinctly. When found, and its exact position determined, the blades of the litholabe are expanded by pushing downwards the rim attached to its upper extremity, taking especial care to keep one blade directed upwards towards the linea alba, and parallel with the graduated scale, which should always be uppermost, and correspond with the screw on the silver

or external cannula, while the other blades lie along each side of the bladder, and in this position can hardly fail to enclose the stone. By attention to this rule, which is extremely important, it is impossible for one of the branches to fall vertically upon the stone, and the surgeon, instead of enclosing it by chance or accident, seizes it to a certainty, by drawing the litholabe upwards with the right hand, while the left is employed in pushing down the external cannula. To secure the stone firmly in the grasp of the claw, the screw, which traverses the rim of the external cannula, should be turned, and the two tubes rendered immoveable or prevented from sliding upon each other. The next step is to attach the frame or lathe to the lithontripteur, to adjust the upper extremity of the perforator to the steel pivot projected by the spiral spring of the popet head, to apply the catgut to the pulley and rotate it by very slow and gentle movements. If the stone is found not to change its position by the action of the perforator upon it, and the patient does not complain of the motion of the bow, the rapidity of the drilling may be increased and continued until the stone is perforated. When soft this is soon accomplished, but when hard requires some time, and is attended with a good deal of fatigue to the operator. In general, it is best not to attempt too much at the first operation. Having, therefore, succeeded in boring the stone at a single spot, the next step is to remove it from the claw of the instrument. This is done by expanding the blades, pushing out the stone by the perforator, then closing them and removing the instrument from the bladder. In doing this, however, great care must be taken that no fragments are interposed between the blades and drill, as often happens, but may be discovered by the difficulty of withdrawing the instrument. A few turns of the crown of the perforator, in such a case, will be sufficient to pulverize and remove them. After the operation the patient should take a warm bath, keep quiet for some hours, and attend to his diet. The urine first discharged is generally found slightly tinged with blood, and along with it pass off more or less sand and fragments of the stone. In three or four days the patient is ready, in most cases, for a second operation.

In the details just given, I have followed closely the directions of Civiale, and have reason to believe, that, if pursued with minute attention to all the points enumerated, that much

less difficulty will be experienced by operators in this country, who may now resort to the operation, than has been the case hitherto; for I am persuaded that most of the mishaps recorded in former editions of this work, are imputable to want of attention to certain indispensable practical manipulations, the neglect of which must still eventuate in inevitable failure. But to guard, as much as possible, against ill consequences, I shall endeavour still further to inculcate such precepts, from the best authorities, as will be likely to prevent error and to facilitate the efforts of those who may feel disposed to engage in this branch of surgery, and may not have access to those European productions which have issued, latterly, in such numbers from the press.

Notwithstanding the facility with which, in many cases, the stone is seized immediately upon expanding the branches of the litholabe in the bladder, yet it sometimes happens, that it pertinaciously eludes their grasp. This is owing, generally, to the stone resting near the neck of the bladder, so that it comes in contact with the smallest diameter of the branches—that which is next to the extremity of the cannula. This will be understood, easily, when it is recollected that the branches, when opened into the bladder, represent a triangular pyramid, the base of which presents to the sacrum, and the apex to the neck of the bladder. The course to pursue, under such circumstances, is either to withdraw the instrument and raise still higher the hips of the patient, in order to roll the stone towards the fundus of the bladder, or else to draw the instrument with its blades expanded towards the penis, which must have the effect of gaining room by expanding the neck of the bladder, (naturally elastic, and susceptible of dilatation,) and of bringing the claws at the point of their greatest divergence, over the sides of the stone. Still further to facilitate its enclosure, it may be necessary to raise the handle of the instrument, by which the two *lateral* blades must depress the prostate and embrace the sides of the stone, while the *vertical* blade descends and rests upon its summit. Having in this way succeeded in seizing the stone, the handle of the instrument should be depressed, by which manœuvre the stone will be suspended, as it were, in the centre of the bladder, and being sustained in that position while

the drilling is going on, there will be no pressure or irritation on the walls of the bladder.

If the stone, as often happens, should be too large to be embraced by the litholabe, this may be easily known by its retiring from the instrument when its claws are expanded to the utmost, and may be proved by examination of the graduated scale. In such a case the lithontripteur is removed, and another of larger dimensions substituted. When the stone does not exceed in bulk a hen's egg, it may be destroyed by the operation of lithotrity, but if larger, the surgeon will act wisely in not attempting the operation.

The most delicate and difficult part, perhaps, of the operation of lithotrity is the *turning* of the stone, in order to perforate it in different directions; for after the first operation, and in all subsequent ones, this will become an important indication. The assistance of the *lithotriteur*, upon such occasions, is of the utmost importance. By moving this in different directions, sometimes pushing it forward, sometimes rotating it, and making it bear lightly upon the stone, the latter can be made to shift its position while still in the relaxed embrace of the claw, and as soon as the operator finds that the crown of the lithotriteur bears upon a surface not previously bored, the stone may be again seized and the drilling renewed. Having, in this way, perforated the calculus, in numerous directions, it becomes so hollowed out, and weakened, that it may often be crushed by the pressure of the claw. Soft and friable stones, indeed, as Civiale and others have proved, may be destroyed, sometimes, by the litholabe alone, and without the aid of the perforator.

Before attempting lithotrity, it is of the utmost consequence to measure, *exactly*, by means of a catheter, (having on its side a graduated scale) the exact length of the urethra, which varies, as is well known, in different subjects. As soon as the urine begins to flow, the measurement may be taken. Knowledge, thus obtained, will prevent the operator from attempting to open the blades of the litholabe whilst in the *urethra*, from which very serious mischief has ensued in several instances.

Although the necessity of *injecting* the bladder, upon all occasions, whether for the purpose of exploring its contents, (which is sometimes done with the blades open as well as shut,)

or for seizing the stone, has been mentioned, already, as essential, yet it may be well to state, in this place, that without such preliminary measure, success can hardly be calculated upon. No difference of opinion exists among lithotritists upon this point, and, perhaps, it may be owing to attention in this respect, that Civiale has never, as he declared, some years ago, injured the sides of the bladder, although he had, at the time the declaration was made, introduced the lithontripteur upwards of five hundred times. Should the fluid then escape, upon any occasion, previous to operation, there can be no safety unless the bladder is again filled before the introduction of the instruments.

As regards the number of applications of the lithontripteur, that may be required, before the cure is completed, it may be remarked, that this will depend upon the size and texture of the stone, upon the state of the patient's health, upon the condition of the bladder, and a variety of other circumstances. In general, when the stone is soft and small, from one to three operations will be required, and a greater number when it is large and hard. In getting away the fragments, little difficulty is now experienced. They usually pass off along with the urine, from day to day, or are brought away by injections, or by the repeated introduction of the litholabe, or by forceps with two blades, and if too large to pass the urethra, may be easily crushed. Instruments, indeed, have been invented by Jacobson, Heurteloup, Weiss, and others, for crushing stones, or for breaking them with a hammer, and have been found calculated, upon certain occasions, to supersede the *lithontripteur*. One of this description, admirably contrived for the purpose, either invented or modified by Civiale, was lately sent to me, by that distinguished operator.

Upon the whole, it may be stated that as *lithotrity* can never entirely supersede *lithotomy*, though it will undoubtedly greatly curtail it, the surgeon should strive to make himself so familiar with both operations, and with calculous disorders, as to be able to determine the kind of operation adapted to each particular case, and prepared to perform either, as occasion may require. Upon his *judgment* in this respect, I venture to predict, will his success, or failure, in a great measure depend. Death has followed both operations, in numerous instances, although per-

formed by Civiale himself, less frequently, however, since the various modifications of the instrument, and experience acquired in using them, than in the infancy of the art. Although Leroy, and some others, have performed lithotrity upon *children* of three and four years of age, and in a few cases with success, as a general rule it should not be attempted, on account of the sensibility of such subjects, and the difficulty of introducing instruments sufficiently large and strong to destroy the stone. In *women*, lithotrity is more difficult than might be imagined, owing to the very irritable condition in which the female bladder, when it contains a stone, is generally found, and to the difficulty of keeping it distended, during the operation, with fluids.

On Lithotrity, consult *de la Lithotritie ou Broiement de la Pierre dans la Vessie, par le Docteur Civiale*, 8vo. Paris, 1826—*Exposé des divers procédés, employés jusqu'à ce jour, pour guérir de la Pierre sans avoir recours à l'Operation de la taille; par J. Leroy*. Paris, 1825, 8vo.—*Lettres sur la Lithotritie, ou Broiement de la Pierre dans la Vessie, par le Docteur Civiale*. Paris, 1827, 8vo.—*Lettre sur la Lithotritie, &c., par le Docteur Civiale*. Paris, 1828, 8vo.—*Lettre sur la Lithotritie Urétrale suivée d'une revue générale, sur l'état actuel de la methode Lithotritique, par le Docteur Civiale*, 8vo. Paris, 1831—*Lettres sur la Lithotritie ou l'Art de broyer la Pierre, par le Docteur Civiale*, 8vo. Paris, 1833—*Manuel Pratique de la Lithotritie, par A. P. Bancal*. Paris, 1829, 8vo.—*Description of the new Process of perforating and discharging the Stone in the Bladder, &c., by James Atkinson, Esq.*, 8vo. London, 1831—*Lithotrity and Lithotomy compared, being an analytical Examination of the present Method of treating Stone in the Bladder, &c., by Thomas King, M. D.* London, 1832, 8vo.—*Principles of Lithotrity, or a Treatise on the Art of extracting the Stone without Incision, by Baron Heurteloup*, 8vo. London, 1831—*Case of Lithontripty, successfully performed by L. Deyperc, in New York Med. Journal, for Nov. 1830*—*A. G. Smith on Lithotrity, in North Amer. Med. and Surg. Journal, vol. 12th, p. 256*—*The Operation of Lithontripty, by Jacob Randolph, M. D., in American Journal of Medical Sciences, No. 29, Nov. 1834*—*Spencer's Case of Lithotrity.---Ibid. Aug. 1833. No. 24.*

CHAPTER X.

DISEASES OF THE EYE.

THE eye, from its delicate and complex structure, and the number and diversity of its diseases, was formerly much neglected, especially in Europe, by the regular members of the profession, and attended to almost exclusively by ignorant and itinerant oculists. Within the last twenty years, however, the value of this important branch of surgery has been duly estimated, in proof of which it need only be mentioned that Ware, Saunders, Gibson, Adams, Wardrop, Travers, Vetch, in Britain, and Scarpa, Beer, Schmidt, and others on the continent, have contributed largely by their writings and operations to elevate this department to a most respectable rank. Many of these gentlemen, indeed, forsaking the general practice of their profession, have devoted their whole attention to ophthalmic surgery, and with a result truly honourable to themselves, and glorious to their country.

The most common affection, perhaps, of the eye, is ophthalmia. Of this, therefore, it will be proper first to treat. Ophthalmia is employed by most modern writers as a generic phrase—denoting ocular inflammation. For the sake of precision and accurate discrimination, other terms have been invented, some of them simple and expressive enough, others formidable in the extreme, or altogether monstrous.* To elucidate the varieties

* Nothing short of affectation or pedantry will enable us to tolerate, in many instances, the phraseology of Beer and Schmidt—such as ophthalmo-blennorrhœa, blepharo-ophthalmo-blennorrhœa, dacryoadenitis, blepharophalmitis idiopathica,

of the disease, I shall not follow the exact arrangement of any individual author, but endeavour to simplify as much as possible, and oppose every distinction which is not perfectly clear and obvious.

anchyloblepharon, symblepharon, and a hundred more, either of which surpasses in complexity the old anatomical mouthful, baseochondroceratoglossus, &c.

SECTION I.

Conjunctival Ophthalmia.

Conjunctival inflammation, to denote which some writers employ the word *ophthalmitis*, is the most common form of ophthalmia, and is characterized by the following symptoms—a sense of uneasiness, or itching, an impatience of light, diffused redness of the conjunctiva, pain, heat, and swelling of the globe of the eye, and epiphora or increased secretion of tears, a pungent pain, proceeding apparently from the lodgement of a particle of sand or some other extraneous body, but in reality from one or more bundles of enlarged vessels. To these symptoms are superadded, if the inflammation continues to advance, deep-seated, pulsatile and violent pain in the eye-ball, which extends to the forehead, accompanied by fever and other general indisposition. Very often, moreover, the conjunctiva becomes thickened, and projects in a fungous form beyond the margin of the cornea. At other times blood is extravasated between the conjunctiva and sclerotic coat. In the still further advanced stages of the disease, suppuration is liable to ensue, followed by destruction of the cornea, evacuation of the humours and abolition of sight. It is seldom, however, that a simple conjunctival ophthalmia terminates so unfavourably; on the contrary, the symptoms gradually decline, and the eye is restored to its natural state, though sometimes the disease assumes a chronic form, and is then very difficult to manage.

The causes of conjunctival ophthalmia are, for the most part, exposure to extremes of cold and heat, sleeping in the open air without cover, too intense and vivid a light to the eye, whether direct or reflected, blows, wounds, irritation from the

lodgement of extraneous bodies upon the globe or between the eyelids, disorder of the digestive organs, &c.

Catarrhal ophthalmia is a variety of conjunctival inflammation exceedingly common on the continent of Europe, and sometimes met with in this country. It is frequently epidemic, and occasionally accompanies influenza. It is marked in the early stage, by a peculiar dryness of the eye and eyelids, and by a pungent pain near the caruncula lacrymalis. In a few days these symptoms diminish, and are followed by a copious flow of tears, and a mucous discharge, which is generally so acrid as to excoriate the eyelids and adjacent parts of the cheek. The patient is scarcely ever free from fever. In severe cases of the disease the whole conjunctiva is covered with small pustules, containing purulent matter or a yellowish serous fluid.

Purulent ophthalmia differs from the catarrhal in many respects. It is a very formidable and destructive disease, and sometimes destroys one or both eyes in the course of a few hours. Adults, as well as children, are liable to it, but especially the latter. It usually commences four or five days after birth, by a slight redness and tumefaction of the conjunctiva lining the eyelids. This is speedily followed by the secretion of a thin adhesive matter, which glues the lids together. In a few hours the discharge becomes very copious, thicker in consistence, acquires a yellowish or greenish cast, and is so acrid as to excoriate the cheeks. From the lids the inflammation extends to the conjunctiva covering the ball of the eye, and the whole membrane is converted into a thick fungous mass; which, when the eyes are opened, projects beyond the lids, and obscures the cornea. If the disease should continue to spread, the cornea is next involved, and either ulcerates or sloughs, the humours are discharged, and the eye lost. A great deal of constitutional irritation attends the early stage of the disease, but this subsides in three or four days, and the ophthalmia then assumes a chronic form.

To assign any satisfactory explanation of the origin of purulent ophthalmia is very difficult. Some writers suppose it to be closely allied to the gonorrhœal ophthalmia, others that it proceeds from leucorrhœa; the matter of which, in both instances, is applied, it is imagined, to the eyes of the child during

its passage through the vagina. Mr. Saunders is inclined to believe that the inflammation is of the erysipelatous kind.

Gonorrheal ophthalmia, another variety of conjunctival inflammation, bears a striking similitude to purulent ophthalmia, that form of it especially which is so prevalent in Egypt and other eastern countries, and from which the British and French troops, a few years back, suffered so severely. The symptoms, however, are, in every respect, more vehement, and such as to terminate almost invariably in the loss of one or both eyes. That it follows, in many instances, the direct application of the gonorrhœal virus, I have the strongest proofs; having had, at different times, patients under my care in whom the disease was produced by the practice, so common among the vulgar, of washing inflamed eyes with urine. There is reason to believe, also, that the disease is sometimes induced by sympathy or a metastasis, in consequence of suppressed gonorrhœa.

Scrofulous ophthalmia, a disease very common amongst scrofulous children, may be distinguished from other affections of the conjunctiva by a peculiar morbid irritability of the eye, or intolerance of light, unaccompanied with pain, which obliges the patient to keep the lids constantly in a half closed state, and confine himself altogether to a dark room. In addition to this, numerous distinct vessels may be seen running towards the cornea, some of which pass to the centre of that tunic, and terminate in a small pustule or ulcerated spot. This disease may continue for months together, without much alteration, and is very apt to be followed by corneal specks.

Treatment of Conjunctival Ophthalmia.

In the early stage or acute form of simple inflammation of the conjunctiva, the disease may be removed, in a short time, by general and local blood-letting, mild purgatives, nauseating doses of antimony, low diet, blisters behind the ears, or on the

back of the neck, lotions of tepid water, a solution of opium, or of the acetate of lead. If, in spite of this treatment, the inflammation should not terminate, but runs into the chronic stage, cold astringent washes and stimulating ointments may then become necessary, such as the vinous tincture of opium, the citrine ointment, the ointment of the red oxide of mercury, &c.

For *catarrhal* ophthalmia the best remedies are moderate depletion, at first, and afterwards highly stimulating collyria and ointments.

Purulent ophthalmia, in the commencement, should be treated upon common antiphlogistic principles, and by moderately astringent washes, introduced into the eye by means of a syringe. The best lotion for this purpose is the undiluted liquor of the acetate of lead. In advanced stages of the disease, an infusion of two drams of the leaves of tobacco in eight ounces of water, was found highly serviceable by Mr. Vetch, in restraining the discharge, relieving pain and removing watchfulness. The aqua camphorata of Bates' Dispensary has been praised as extremely efficacious in the chronic form of purulent ophthalmia. I have often tried it, however, without benefit, and sometimes with manifest aggravation of the symptoms.

Gonorrhæal ophthalmia, unfortunately, admits of no relief; at least, in several instances of the kind which have fallen under my care, and in others which have occurred in the practice of Dr. Physick, no benefit whatever has resulted from any mode of treatment that could be devised. Mr. Vetch, however, with great confidence states, that the disease may be certainly cured by those remedies adapted to the treatment of Egyptian ophthalmia.

Scrofulous ophthalmia seldom requires antiphlogistic measures; on the contrary, a tonic plan of treatment will generally be indicated. In the commencement of the disease, however, it may be necessary to purge the patient, regulate strictly his diet, order warm clothing, moderate exercise in the open air, &c. To alleviate the intolerance of light, which is so much complained of by all patients in this disease, a blister at the back of the neck, kept open by savin cerate, will be found the best remedy. Sometimes the internal use of mercury will be required. The best collyria are those composed of weak solutions of the argentum nitratum, of sulphate of zinc, alum. &c.

SECTION II.

Sclerotic Ophthalmia.

AN inflammation of the sclerotic coat described by many writers under the name of *rheumatic* ophthalmia, is often met with. That it is closely allied to rheumatism is exceedingly probable, both from the circumstance of its being a frequent concomitant of that disease, and from the nature of the texture which it occupies. The pain in the commencement of the disease, is generally seated in the temple, and extends thence to the eyebrow, cheek and eye of the affected side. It is constantly present, but commonly most severe during the evening and late at night. The eyeball itself, when examined, does not present the common appearances of conjunctival inflammation. There is no purulent discharge, nor does the patient complain of intolerance of light. The vessels, moreover, instead of following a tortuous course, run in parallel lines upon the sclerotic coat, and terminate at the margin of the cornea. These vessels are small and very numerous, and from being distributed over the whole albuginea, give it a uniform red colour; the redness, however, is not of the bright scarlet or vermilion hue, but of a dingy, brick-dust tinge. More or less fever, and derangement of the digestive organs, generally accompany the disease; and in bad cases, the inflammation may run so high as to involve the cornea and destroy the eye.

Treatment of Sclerotic Ophthalmia.

The chief indications in the treatment of this disease, are to restore, by means of emetics and purgatives, the functions of the stomach and biliary organs, or, if the inflammation has been induced by exposure, to excite the skin by antimonials. Afterwards bark may, perhaps, be employed with advantage. The best local applications are a blister behind the ears, and the free use of the vinous tincture of opium as a collyrium.

General, as well as local blood-letting, will, in certain cases of this disease, prove serviceable, but in others injurious. Hence, the variety of opinions entertained on the subject by different surgeons; some contending that the depleting system should never be pursued, others, that it is indispensable. When accompanied by a full pulse, and met with in plethoric patients, general blood-letting, leeches to the temple, or forehead, or around the eye, will almost always relieve the pain and other urgent symptoms; but when the complaint occurs in thin, and debilitated subjects, has been of long standing, or connected with general rheumatism, little or no benefit may be expected from venesection. Opiate frictions to the temples are extolled by Beer and other oculists, and belladonna to the eyelids and superciliary ridges. Applications to the ball of the eye, with exception of wine of opium, so useful in other forms of ophthalmia, are seldom of much service in this variety of the complaint.

SECTION III.

Iritic Ophthalmia.

THE term *iritis* was employed by Mr. Saunders to denote a variety of ophthalmic inflammation which previous to his time had been very little attended to. From the peculiarity and distinctness of the symptoms, there can be no question as to the propriety of considering the disease purely an inflammation of the iris, and totally independent of every other species of ophthalmia. These symptoms are severe lancinating pain extending from the eyebrow to the orbit; and shooting thence through the globe of the eye towards the optic nerve, extreme impatience of light, and an extraordinary morbid sensibility of the eye. Unlike most other varieties of ophthalmia, iritis is unaccompanied by redness of the conjunctiva, but the sclerotic coat is covered with numerous red vessels, which are particularly conspicuous on that portion of it connected with the margin of the cornea. On the iris, also, at least on its anterior surface, red vessels may be distinctly seen; but the most remarkable change that this membrane undergoes, is the loss of its brilliancy, and a change from its natural colour to that of a reddish or greenish hue. At the same time the pupil becomes contracted and irregular, and its edge is turned backwards towards the crystalline lens. Instead of terminating in suppuration, the inflammation generally stops at the adhesive stage, and lymph is deposited upon the outer surface of the iris in one or more spots, and is sometimes secreted so copiously as to fill the anterior chamber. From this cause, incurable obliteration of the pupil often ensues.

The causes of iritic ophthalmia are various. Sometimes the disease is induced by exposure of the eye to intense or vivid light; sometimes it proceeds from wounds of the iris made by

the cornea knife or couching needle; at other times it appears to arise from some constitutional affection, such as gout. In the greater number of instances, however, it is the result of syphilis or of the abuse of mercury.

Treatment of Iritic Ophthalmia.

The antiphlogistic system, carried to its full extent, will barely prove sufficient, in many instances, to arrest the progress of this severe disease. Hence the propriety of resorting to it as speedily as possible after the inflammation has set in. To guard against obliteration of the pupil, by breaking up the bands of coagulable lymph which extend across it, the extracts of belladonna or stramonium will be found immensely serviceable. They should be applied to the outer surface of the eyelids, or over the eyebrows two or three times a day, and kept on for half an hour at a time. Care should be taken, however, not to employ them during the height of the inflammation. For the removal of *syphilitic* iritis, the moderate use of mercury, followed up by sarsaparilla, will generally prove an efficient remedy.

SECTION IV.

Psorophthalmia.

SOME of the German writers understand by psorophthalmia, a variety of inflammation of the eyelids, induced by psora or itch. In the usual acceptation of the term, however, nothing more is implied than simple inflammation or ulceration of the lids, whether induced by small-pox, measles, scrofula, erysipelas, sties, or any other cause.

Children, particularly those of scrofulous constitution, are very subject to this disease; adults, however, are not exempt from it. The inflammation first appears on the edges of the lids, and extends thence along the conjunctiva towards the globe of the eye. The pain is sometimes very severe, and the redness considerable, but the most distressing symptom is the intolerable itching, to relieve which the patient is obliged constantly to rub the affected part; and in this way only aggravates the disease. Sometimes the inflammation runs so high as to terminate in suppuration. This is followed by troublesome ulceration of the tarsi, and frequently by great deformity. The meibomian glands are always more or less affected in this complaint, and pour out an adhesive fluid, that glues the lids together during sleep. To open these, in the morning, some force is usually employed, and this keeps up constant irritation, and frequently renders the disease chronic, causing the formation of small crusts or scabs along the tarsi and the cilia to drop out. In bad and long-standing cases of the disease, the puncta lacrymalia are sometimes permanently obliterated, and an incurable epiphora is produced.

Treatment of Psorophthalmia.

In the early stage of this disease, purgative medicines and a moderate diet will contribute very much towards a speedy cure. Weak solutions of the acetate of lead, of the sulphate of zinc, or sulphate of copper, will also be found useful as collyria. To prevent the lids from adhering, a very important indication in the treatment, a little fresh cream or butter should be placed between them every night before the patient retires to rest. After the inflammation has, in a measure, subsided, and is verging towards the chronic stage, the unguentum hydrargyri nitrati, applied to the edges of the lids, two or three times a day, will prove singularly useful in relieving the itching, and in healing the ulceration. With the same view, an infusion or decoction of the pith of the sassafras is sometimes used, and in many instances with decided advantage. Not unfrequently the disease resists, for a long time, every remedy, and, indeed, continues for years together. Under these circumstances, blisters behind the ears and neck, and a course of mercury may prove useful.

SECTION V.

Pterygium.

THE pterygium, or eye wing, is a thin membranous expansion seated upon the conjunctiva. It commonly occupies the inner angle of the eye, in the shape of a triangle, the apex of which looks towards the cornea. The disease is very common, but in most instances productive of so little inconvenience, that many persons are subject to it for years together, without being aware of its presence. In the early stages, it resembles a globule of fat, and appears to possess little vascularity; a slight cold, however, or an inflammation of the conjunctiva, renders its vessels very distinct. Although the disease may remain stationary, or nearly so, for many years, it is always liable to increase, and in this case may extend over the surface of the cornea. But it is somewhat remarkable, that it seldom, if ever, passes beyond the semidiameter of the cornea. Sometimes a pterygium originates at each angle of the eye, and approaching the cornea in opposite directions, covers the whole of its surface. The disease is then called a pannus. There are two varieties of pterygium—the membranous and fleshy.

Treatment of Pterygium.

So long as this membranous excrescence continues small, and does not encroach upon the cornea, it will seldom be necessary

to resort to an operation for its removal. When, however, it has attained considerable bulk, and is a frequent source of irritation, it should be dissected off either by a small scalpel or curved scissors. The scissors will generally be found the most convenient. To perform the operation advantageously, an assistant should stand behind the patient and support his head firmly upon his breast, and with one or two fingers elevate the upper eyelid, whilst another assistant depresses the lower lid, and keeps it fixed. The surgeon then taking a pair of small forceps should elevate the pterygium from the conjunctiva, and by a few strokes of the scissors separate the whole of it from the globe. A smart and sometimes violent inflammation follows the operation, and this must be subdued by the usual remedies.

SECTION VI.

Encanthis.

THE encanthis, an enlargement of the lacrymal caruncle and semilunar fold, is a very uncommon, but sometimes most malignant disease. It proceeds, in some instances, from obstinate and protracted ophthalmia; at other times the gland assumes a cancerous action, and terminates, like most diseases of this description—unfavourably. In every disease of the kind, whether benign or inveterate, the caruncula lacrymalis presents a granulated and livid aspect. In proportion, however, as the tumour increases, its surface becomes less rugged, and is covered with varicose vessels. From the caruncle the disease extends sometimes to the cornea, and along the inner surface of each eyelid. When the tumour attains a large size, the puncta lacrymalia are commonly compressed or obliterated, and a troublesome epiphora ensues.

*Treatment of Encanthis.*

Excision of the caruncula and of the valvula semilunaris is the only remedy for this disease; but the operation frequently fails either from the whole of the tumour not being taken away or from the malignant character of the complaint. In performing the operation, the surgeon will find it most convenient to secure and control the tumour, by introducing a small hook into its substance, and then dissecting it out with a narrow scalpel. Care must be taken to avoid the puncta lacrymalia. If the tumour has taken on the cancerous action, is very large, and has involved the surrounding parts, it may become necessary to extirpate the globe of the eye.

SECTION VII.

Opacity of the Cornea.

THERE are three varieties of corneal speck, noticed by most writers under the names of nebula, albugo, and leucoma. By nebula is commonly understood a "superficial opacity of the cornea, preceded and accompanied by chronic ophthalmia, through which the iris and pupil are seen, and which does not, therefore, entirely take away from the patient the power of seeing, but only causes the surrounding objects to be seen as if covered with a veil or cloud."* The whole cornea is sometimes covered by a nebula; in other instances, several distinct specks appear in spots upon its surface, each of which is generally supplied with one or more vessels from the conjunctiva, or other coats of the eye. These vessels, indeed, serve to nourish or keep up the disease.

The *albugo* differs in several respects from the common nebula. It is more deeply seated, and occupies the lamellæ or substance of the cornea; it is also of a white or pearl colour, is frequently unaccompanied by ophthalmia or by red vessels, and is always the result of an abundant effusion of lymph.

Leucoma is a dense callous speck of the cornea of a pure white or chalk colour, and polished aspect. It is usually the result of a cicatrix from a wound or ulcer. Sometimes it follows small-pox or measles.

* Scarpa.

Treatment of Opacity of the Cornea.

A simple *nebula* or cloudiness of the cornea, may often be dispersed by slightly astringent collyria, such as are calculated to subdue the ophthalmia that usually accompanies the disease. But, in many instances, a division of the vessels supplying the speck is rendered necessary. If the trunks are large, they should be elevated by forceps, and a piece taken out of each by the curved scissors.

The treatment of an *albugo* of long standing will always be found very difficult, and nothing short of highly stimulating applications will effect a cure. One of the best for this purpose is the unguentum hydrargyri nitrati, applied by means of a camel hair pencil to the surface of the speck once or twice a day. A weak solution of argentum nitratum, will, in most cases, prove very serviceable. The same may be said of sulphate of copper, and of corrosive sublimate. Red precipitate ointment, also, is a very useful remedy. Finely powdered loaf sugar, calomel, and other similar articles, are frequently blown into the eye, and produce most salutary effects. A drop of molasses, between the lids night and morning, has frequently dispersed both nebula and albugo. In several obstinate cases of the disease which have resisted all the usual remedies, I have known a speedy absorption of the speck accomplished by the repeated ablution of the eye and eyelids with diluted vinegar. In addition to the local treatment, the internal use of calomel and other preparations of mercury should be resorted to. The *leucoma* is seldom, if ever, removed.

SECTION VIII.

Ulcer of the Cornea.

THE cornea, as well as the fine lamina of conjunctiva covering its surface, is liable to assume the ulcerative action. In either case, a very troublesome, and, perhaps, destructive disease may be induced. This ulcer is commonly the result of the different varieties of ophthalmia, or it may proceed from the introduction of acrid or caustic substances into the eye. Sometimes the whole cornea is covered by the ulceration; at other times, a small dimple-like cavity, not larger than the head of a pin, occupies some particular part of the cornea, and instead of spreading towards its margin, penetrates the layers until it lays open the anterior chamber of the eye. An ash-coloured slough, resembling wet pasteboard, generally covers the surface of the corneal ulcer. The edges of the ulcer, also, are high and serrated.

*Treatment of Ulcer of the Cornea.*

To relieve the excessive pain that usually attends this disease, and to promote healthy granulation, there is no application so effectual as the *argentum nitratum*. The sore should be lightly touched with the caustic, until an eschar forms on its surface, and when this drops off, which it generally does in

twelve or eighteen hours, the application should be renewed—taking care to wash away, with milk and water, any superfluous caustic that may happen to lodge about the eye or eyelids. When the ulcer assumes a healthy aspect, the caustic may be discontinued, and mild collyria or ointments substituted.

“In all cases,” says M’Kenzie, “we endeavour, of course, to check the ulcerative process, by those measures which are fitted for subduing the inflammation in which the ulcer took its origin. So long as there is an appearance of activity in the inflammatory disease, and much pain of the eye, local blood-letting must be employed. The bowels must be kept freely open, and opium administered in such a combination as shall be likely to operate on the skin. In strumous cases, sulphate of quinine operates very advantageously. In chronic superficial ulcer, calomel given so as to affect the mouth is sometimes necessary. In almost all cases of ulcerated cornea, counter-irritation will be found useful. As the inflamed state of the eye abates, the patient finds the pain greatly relieved, and we observe the ulcer clearing and beginning to contract.”

SECTION IX.

Staphyloma.

IN the sense affixed to it by most modern writers, the term staphyloma implies a thickening and opacity of the layers of the cornea, together with a greater or less projection of the anterior surface of that tunic. Children, in whom the cornea is proportionably thicker than in adults, are most subject to the disease. One eye or both may be affected at the same time or in succession. Small-pox, purulent ophthalmia, wounds of the eye by the couching needle or extracting knife, blows, and other injuries, are among the most frequent causes of staphyloma. In the advanced stages of the disease, the tumour of the cornea is sometimes partially absorbed, and both the anterior and posterior chambers of the eye appear to be filled with a serous fluid. Two forms of the disease are met with—one in which more or less transparency of the cornea is preserved, and, along with it, a slight degree of vision, the other, in which the whole cornea is perfectly opaque. The former is denominated *partial*, the latter *total* staphyloma. Again; staphyloma has been divided into *conical* and *spherical*.

Treatment of Staphyloma.

There is no remedy, unfortunately, for this disease; at least the transparency of the cornea cannot be restored, and the patient,

therefore, must for ever remain blind. But the surgeon, generally, has it in his power to alleviate the severe pain and inflammation (caused by dust and other extraneous bodies lodging upon the portion of the cornea projecting beyond the eyelids) by an operation. The object of this is to evacuate the humours, and permit the eye to collapse. To accomplish this purpose most effectually, and prevent a return of the disease, a section of the most prominent part of the cornea, by the knife used for extracting the cataract, should be made. The humours having escaped, the flap of the cornea may be removed with curved scissors. A circular opening will thus be made large enough for the contents of the eyeball gradually to drain away, whereas, if the surgeon were merely to puncture the cornea with a needle, as formerly practised, the opening would soon close, and the disease return.

However, it has been recommended, and practised, by many modern oculists, not to evacuate the contents of the eye, if it can be avoided, but suffer the humours to remain, and endeavour to produce cicatrization of the cornea, in order that the rotundity of the eye may be preserved, and the deformity arising from the collapse of the organ obviated. With this view, all pressure upon the eye after the section of the corneal tumour must be avoided, the lids immediately closed by court plaster, and not opened for several days. In *conical* staphyloma it is more difficult to prevent the humours from draining off than in the *spherical* variety.

SECTION X.

Hypopion.

IN consequence of violent deep-seated ophthalmia, it sometimes happens, that purulent matter is formed within the posterior or anterior chamber of the aqueous humour—constituting the disease known under the name of hypopion. Besides extreme redness of the conjunctiva, a yellowish crescent-shaped spot may also be observed at the bottom of the anterior chamber, which gradually increases in size until the whole of the cavity is filled. During the height of the inflammation, the pain, intolerance of light, &c., are intensely severe, and the matter copious; but as these symptoms decline, the pus is proportionably absorbed and sometimes disappears in a few days without material injury to the eye. In other instances, it remains for weeks together, after the inflammation has entirely subsided, in the anterior chamber, mixed with the aqueous humour, which it renders turbid. It is seldom, however, that the disease terminates so favourably. On the contrary, in bad cases of the kind, ulceration and sloughing of the cornea are apt to ensue, followed by discharge of the humours and destruction of the whole eye. When the matter is lodged between the lamellæ of the cornea, the disease takes the name of *onyx* from its resemblance to the white spot at the root of the nails.

Treatment of Hypopion.

The proper mode of managing this disease is not to puncture the cornea and evacuate the matter, as some advise, but to sub-

due the accompanying inflammation, after which it will be found, commonly, that the matter is slowly absorbed, and will, in time, entirely disappear. When, however, the collection of pus is so large and the inflammation so violent, as to leave no hope of saving the eye, it may become expedient to open the cornea and discharge the matter, in order to relieve the patient from unnecessary pain and irritation.

Nevertheless, cases have been reported by Wardrop, Monteith, and others, where, in the early stages of onyx and hypopion, the aqueous humour has been evacuated, and the purulent matter discharged, with speedy relief to the patient, and preservation of the eye. From statements made by Monteith, in particular, it also appears, that what, in many instances, seems to be pus, is, in reality, lymph, as is proved by its consistence, and other properties, and that its removal checks the disposition to suppuration. Scarpa, long ago maintained, that the fluid poured out into the anterior chamber, in cases of hypopion, was, generally, lymph, secreted by the choroid coat.

SECTION XI.

Hydrophthalmia.

DROPSY of the eye, a disease rarely met with, may originate either in the anterior or posterior chamber of the eye. It is, for the most part, dependent upon some constitutional affection, and is frequently connected with general dropsy. The most striking symptom of the disease is a gradual enlargement of the globe of the eye, without much pain or injury to vision. When the globe, however, begins to protrude from the socket, and the coats of the eye are rendered tense by the accumulation of serum within their cavities, a considerable degree of pain is experienced, which extends in some instances to the head. At the same time the vision becomes impaired, the aqueous humour acquires a turbid appearance, and the iris appears more deeply seated than usual, and trembles upon the slightest motion of the patient's head. Finally, if not evacuated by an operation, the humours accumulate in such quantity as to excite violent irritation and suppuration, and the eye is irrecoverably lost. Collections of serum between the sclerotic and choroid coats, and between the choroid and retina, are, occasionally, met with—the former termed sub-sclerotic, the latter sub-choroid dropsy. Conversion of the retina into a cord, and absorption of the vitreous humour, may be the result, from pressure, of sub-choroid dropsy, which is much more common than the sub-sclerotic.

Treatment of Hydrophthalmia.

When hydrophthalmia depends upon general dropsy, and is attended to in the commencement of the disease, some benefit

may be derived, perhaps, from internal remedies—such as digitalis, squill, volatile tincture of guaiacum, calomel, cicuta, &c. But after vision has been materially injured, or destroyed and the eye projects beyond the lids, the operation of paracentesis is the only mode of treatment calculated to afford relief. This must be considered, however, as merely palliative. It may be performed with a common lancet or couching needle, and the operation occasionally repeated, or whenever the accumulation of water is such as to require its evacuation.

When the disease proceeds from local causes, such as blows upon the eye or superciliary ridge, and the fluid is confined to the anterior chamber, friction with mercurial ointment around the eyelids, and blisters to the temples will now and then stop the progress of the complaint, and effect a cure. To relieve the violent pain accompanying sub-choroid dropsy, puncture of the eye with a grooved needle at the place where couching is usually performed, should be resorted to. Ware and other oculists report interesting cases, where great benefit followed this mode of treatment.

SECTION XII.

Obliterated Pupil.

FROM common ophthalmia or from iritic inflammation, whether induced by operations for cataract or by other causes, closure or obliteration of the pupil frequently takes place. The iris, under such circumstances, becomes wrinkled or puckered, and the pupil is either entirely effaced or contracted to a very small compass. If complicated with cataract, the opaque lens or its capsule may generally be seen behind the pupil of a whitish or bluish aspect; but if the lens and capsule remain transparent, the pupil, although contracted, still retains its natural black colour; and vision, perhaps, to a certain extent, is still preserved.

Treatment of Obliterated Pupil.

This disease can be relieved, or cured, only by an operation. Since the time of Chessel den, who was the first to resort to such an expedient, various methods have been practised. Chessel den's operation, in his own hands, proved eminently successful; with others it often failed, and was at last abandoned altogether. Recently, however, it has been revived by Sir William Adams, and as modified by him is better calculated, I conceive, for most cases of closed pupil, than any other operation. "The patient being seated as in the operation for cataract, and the eye ren-

dered steady by a gentle pressure with the concave speculum, placed under the upper eyelid, the artificial pupil knife should be introduced through the coats of the eye about a line behind the iris, with its cutting edge turned backwards instead of downwards. The point is next brought forward through the iris somewhat more than a line from its temporal ciliary attachment, and cautiously carried through the anterior chamber until it has nearly reached the inner edge of that membrane, when it should be almost withdrawn out of the eye, making a gentle pressure with the curved part of the cutting edge of the instrument against the iris in the line of its transverse diameter. If in the first attempt the division of the fibres of the iris is not sufficiently extensive, the point of the knife is to be again carried forward, and similarly withdrawn, until the incision is of proper length, when the radiated fibres will immediately contract, and an opening of a large size will be formed. After the operation is thus completed, the eye should be covered over with a plaster of simple ointment, spread on lint, and the patient put to bed with his head raised high.”* If the obliterated pupil should be combined with an opaque lens or capsule, the surgeon should make it a point at the time he divides the iris, to cut up or lacerate these textures, and thrust them forward through the pupil, which they will assist in keeping open.

Wenzel, Gibson, of Manchester, and many other oculists, prefer in cases of closed pupil, a section of the *cornea* and the removal of a portion of the iris with scissors. Under particular circumstances, I should select this operation in preference to that of Chesselden.

Several years ago, Dr. Physick invented a small instrument, resembling a saddler's punch, for cutting out a piece of the iris; but he has never, as he informs me, made use of it. It will, sometimes, become necessary to make an artificial pupil (even although the natural one remain of its usual size) on account of corneal opacity.

Beer, Schmidt, Reissinger, Maunoir, Flagani, Assalini, Scarpa, have all particular modes of operating for obliterated pupil; they possess no advantages, it appears to me, over those in common use.

* Adams' Practical Observations, &c. p. 137.

SECTION XIII.

Procidencia Iridis.

A PROLAPSUS, or projection of the iris through an ulcer or wound of the cornea, is by no means unfrequent. The pain attending the disease is extremely severe, and the intolerance of light so excessive that the patient cannot bear the exposure of the eye for a moment. The pupil, in this disease, always assumes an unnatural shape; its particular form, however, will depend very much upon the situation of the opening in the cornea. Generally, it is of an oval figure. Sometimes there are two or three projections of the iris, each of which passes through a distinct opening of the cornea. After the protrusion has continued for some time, an adhesion is apt to ensue between the cornea and iris, and the part of the iris that projects beyond the cornea becomes dry and hard, and sometimes sloughs away.

Treatment of Procidencia Iridis.

When this disease follows a wound of the cornea, the iris may always be replaced at the time the edges of the wound are adjusted; but when it proceeds from an ulcerated opening, the surgeon will find it impossible to retain the iris in its natural situation so long as the ulcer exists. The great object, therefore, in the treatment should be to heal the ulcer, and this will be most speedily accomplished by repeated touches of the argentum nitratum. The caustic will serve the additional purpose of subduing the morbid sensibility of the iris, and of removing the superfluous portion of it projecting beyond the cornea.

SECTION XIV.

Cataract.

THE ancients entertained very erroneous notions respecting the nature and seat of cataract. They supposed it to be formed by an adventitious membrane in the posterior chamber of the aqueous humour. Dissection, and operations on the living subject, afterwards proved that the disease was confined to the crystalline lens or its capsule, which becoming opaque prevented the rays of light from passing to the retina.

Cataracts differ from each other as much in consistence as colour. Sometimes the lens is rendered perfectly fluid, and resembles milk, and on this account has been called the *milky* cataract. Sometimes it is found of the consistence of jelly or cheese, and hence the terms *gelatinous* and *caseous* cataracts. Not unfrequently the lens is perfectly *hard*, or ossified, so much so, that the sharpest instrument will make no impression upon it. When the anterior or posterior capsule is rendered opaque, and the lens remains transparent, or is absorbed, the disease is called *capsular* cataract. When a cataract exists at birth, the appellation *congenital* is applied to it. Most cataracts are of a bluish or pearl colour; some are gray or green; others white as snow. In a few rare instances the lens has been found of a brownish tint or perfectly black.

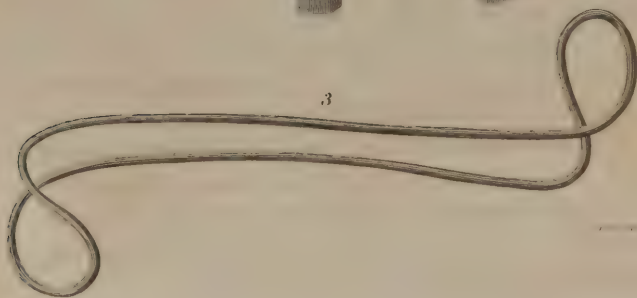
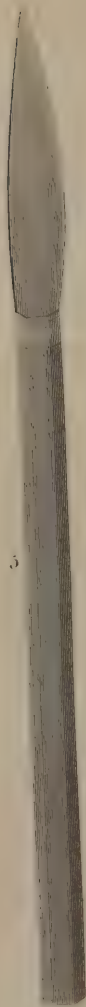
The formation of cataract has never been satisfactorily explained. By some the disease has been attributed to inflammation of the lens and its capsule, by others to hereditary transmission. That it may proceed from blows upon the eye and from wounds of that organ is very certain. In all cases of the kind there is reason to believe that the anterior capsule of the lens is either ruptured or cut, so that the lens itself is brought into immediate contact with the aqueous humour, which possesses the well

known property of dissolving its texture as well as that of its capsule. It is remarkable, however, that an injury or destruction of one eye, as I have several times witnessed, will frequently give rise, at a subsequent period, to a cataract in the other. Old persons are most subject to cataract, though the disease may occur at any period of life; indeed, new-born infants are not exempt from it, and it has sometimes happened that all the children of a numerous family have been born with cataracts in both eyes. Persons whose eyes are much exposed to vivid and reflected lights are said to be peculiarly liable to cataract.

The existence of cataract may be determined, generally, by the following symptoms. In the commencement, the patient is often sensible of a diminution of sight long before any opacity can be observed behind the pupil. Objects, moreover, especially white ones, appear to him as if enveloped in mist or smoke, and when the eye is suddenly exposed to a strong light, vision is nearly destroyed. In a dull light, on the contrary, vision is more distinct, because the pupil being expanded, the rays of light, besides their increased quantity, pass through the thin margin of the lens. When the lens is completely opaque, its colour will commonly indicate the nature of the disease. The black cataract, however, is very liable to be mistaken for amaurosis. Cataracts are said to have been formed very suddenly, or in the course of a night, without any obvious cause; but I am inclined to believe this to be erroneous, and that the disease has existed, at least in one eye, for some time, without the patient being aware of its presence, and that the discovery of it has been purely accidental.

Treatment of Cataract.

Although repeated attempts have been made, both by internal remedies and by local applications, to remove cataract, there is no well-attested instance, I believe, on record, of a cure having



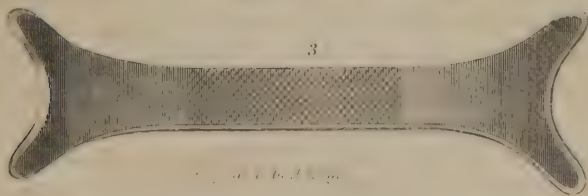
been effected, except by an operation. There are two or three different operations now in use, each of which it will be proper to describe.

Couching or *depression* of the cataract, an operation practised, there is reason to believe, long before the time of Celsus, is usually performed by the modern surgeon either with a curved or straight needle. The former is preferred by Scarpa—the latter by Hey. (See Plate V. figs. 1 and 2.) The patient being seated on a low stool, with an assistant behind to support his shoulders and head, the operator, sitting or standing before him, passes the speculum of *Pellier* (Plate V. fig. 3,) beneath the upper eyelid, and directs the assistant to hold it steadily, while with one or two of the fingers of his own hand he depresses the lower lid. He then takes the needle, (and if Scarpa's be used, which I prefer to any other,) holds it in his fingers like a pen, and laying the handle of the instrument nearly parallel with the patient's temple, directs its point backwards, and its convex surface forwards, and penetrates the coats of the eye, at its external angle, about two lines posterior to the iris. The needle is next pushed towards the superior margin of the crystalline lens, and thence in the direction of the pupil, until its point is distinctly seen. It only remains to lacerate freely, but cautiously, with the point of the needle, the anterior capsule of the lens; which being done, the lens itself should be pressed downwards and backwards by the needle, and lodged in the vitreous humour. Instead of withdrawing the needle immediately after from the eye, as is too often done, it should be suffered to remain a few seconds, lest the lens reascend, in which case the surgeon should again depress it, and then carefully remove his instrument and close the eyelids.

Extraction of the cataract is performed by a *knife* instead of a needle, and the opening made in the cornea in place of the sclerotic coat. There are two knives in general use—the one invented by Wenzel and improved by Ware, straight and blunt on the back, convex on the edge, five-eighths of an inch in width, and in other respects shaped like a wedge, or gradually tapering from the handle to the point—the other invented by Beer, and differing from that of Wenzel chiefly in having a *triangular* shape. (See Plate V. figs. 5 and 6.) With either, the operation may be equally well performed.

The necessary arrangements being made, the patient is placed on a low chair or stool, and his head committed to an intelligent assistant (one accustomed to the office and in the habit of performing the operation,) who with his fingers, instead of a speculum, elevates the superior eyelid, and supports it against the superciliary arch. The surgeon himself taking charge of the lower lid, which he depresses with one or more fingers, and waiting until the patient rolls the eye towards the inner canthus and holds it steady, enters the knife above the semidiameter of the cornea and about a quarter of a line anterior to its junction with the sclerotica, with the edge downwards, passes it slowly and steadily along through the anterior chamber until its point emerges at the inner edge of the cornea. This completes what has been called the *punctuation* of the cornea, and to finish the *section* it is still necessary to push on the blade of the instrument until it cuts itself out. As soon as this is accomplished, the aqueous humour is discharged, the knife is withdrawn, and the lids are closed for a few moments. The next step of the operation, and the most important one, is to separate the lids, gently raise the flap of the cornea with the curette, (Plate VII. fig. 7,) pass a gold or silver wire through the pupil, and cautiously lacerate the anterior capsule of the lens precisely in its centre. If this part of the operation be well managed, and care taken to avoid any thing like pressure upon the globe of the eye, the lens, after its capsule is broken, will gradually approach the surface and be discharged through the opening made in the cornea, without bringing with it any portion of the vitreous humour. As soon as the lens is removed, the flap of the cornea should be adjusted, the lids closed, and a bandage applied lightly over both eyes. It sometimes happens, owing, principally, to the cornea knife being dull and ill-constructed, that the aqueous humour flows before the section of the cornea is completed, and that the iris falls under the edge of the knife, and is liable to be wounded. To guard against this, Baron Wenzel suggested an expedient which has proved extremely important—friction of the cornea with the end of the finger during the passage of the knife. If this plan be adopted, the iris will immediately retire from the edge of the knife, and so remain as long as the friction is continued.

The *absorbent practice*, as it is denominated by Sir William



Adams, may be said, perhaps, to have originated with Mr. Pott; at least, that eminent surgeon was fully aware of the solvent power of the aqueous humour, and frequently took advantage of the circumstance, by pushing fragments of the lens which happened to be detached during the operation of couching into the anterior chamber. Gleize, also, as well as Scarpa, Hey, and others, followed the same practice. But it is chiefly owing to Saunders, Conradi, and Adams, that this mode of removing the cataract has been brought to its present degree of perfection.

There are two operations in use, each founded upon the absorbent principle—the *anterior* and *posterior*. The first, or the operation of Conradi, as it is usually called, is chiefly adapted to the soft or fluid cataract, and may be performed in the following way. The pupil being dilated by the application of the extract of belladonna or stramonium to the eyebrow, an hour or two before the operation, the patient is seated, and the eye secured as in the operation of couching or extraction. With a straight spear-pointed needle, an inch in length, rounded in the shank, and tapering from the shoulder towards the point, (Plate VII. fig. 1,) the surgeon penetrates the cornea, at its lower and outer part, about a line anterior to its union with the sclerotic coat, carries the needle along the plane of the iris and through the pupil as far as the centre of the crystalline lens, the capsule of which is first lightly scratched over its whole surface, then freely torn, after which the lens itself may be broken up and some of its fragments brought by the needle into the anterior chamber. It is highly important, in performing this operation, to guard against wounding the iris; the surgeon, therefore, should not attempt to accomplish too much at a single operation, but calculate, in most instances, upon a second or third being necessary. In general, several weeks elapse before the remains of the capsule and lens entirely disappear.

The *posterior* operation is distinguished from the anterior by the circumstance of the opening being made in the sclerotic coat instead of the cornea. Mr. Saunders was in the habit of performing this as well as the anterior operation; but for many valuable improvements in the mode of executing it, and for the invention of ingenious instruments adapted to the purpose, we

are particularly indebted to Sir William Adams, whose success as an oculist, perhaps, exceeds that of any other individual now living. The needle (Plate VII. fig. 2,) chiefly employed by this distinguished surgeon for "solid cataract in children and adults," is spear-pointed, eight-tenths of an inch long, the thirtieth part of an inch wide, and slightly convex throughout the blade. The eye being fixed by a *concave speculum*, (Plate VII. fig. 3,) the needle is passed through the sclerotic coat about a line behind the iris, perpendicular to its edges, until it reaches the anterior chamber and the nasal margin of the pupil. Its edge is then turned backwards, and at a single stroke made to divide the capsule and its lens. After this, repeated cuts are made in different directions, so as to divide the cataract into numerous pieces, most of which should be pushed afterwards by the flat surface of the needle into the anterior chamber, for solution.

Formerly, Sir William Adams, in cases of *very hard and solid* cataract, was in the habit of introducing a knife similar to that recommended by him for artificial pupil, but smaller, and slicing off pieces of the lens: finding, however, the operation very difficult and sometimes impossible, and having known, in several instances, violent inflammation and even destruction of the eye to follow the lodgement of an entire lens, or of large portions of it in the anterior chamber, he has latterly performed the ordinary operation with his spear-pointed needle, with which he pushes the whole of the lens into the anterior chamber, and thence immediately afterwards extracts it through the cornea by making a section of that tunic with a knife of peculiar shape, (Plate VII. fig. 4,) enlarging the incision, should he find it necessary, with a blunt-pointed curved knife, (Plate VII. fig. 5.)

Besides *couching*, *extraction*, and the *absorbent practice*, other operations have been proposed for the removal of cataract. For the most part, however, they are entitled to so little attention, as to render a description of them unnecessary. But a question naturally arises respecting the merits of the operations in common use, and how far one should be preferred to another; though there is little probability of such a question being ever satisfactorily determined, for, on both sides, it has been customary to extol the merits of one, and exaggerate the inconve-

niences of the other. Perhaps, it may be fairly stated, in relation to the operation of extraction, that under favourable circumstances—where the subject is young, healthy, the eye prominent, the vitreous humour sound, &c.—this operation, when dexterously performed, possesses advantages over every other, inasmuch, as the cataract is at once removed, and a speedy cure follows. But, on the other hand, it must be recollected that the operation is always extremely difficult, and that, if it once fail, it cannot be repeated. As respects the operation of *couching*, it appears to me that the chief objection to it arises from the difficulty of keeping the lens below the axis of vision; in addition to this, from its lodgement, in many instances, upon the retina, great pain and incurable amaurosis have not unfrequently ensued. Under all circumstances, therefore, I am inclined to prefer the “*absorbent practice*,” principally, because the operations are easily executed, give little pain, and, if necessary, may be repeated again and again without injury to the eye, and are the most likely to prove successful.

It should be remembered that previous to the performance of any operation for cataract, the patient must be prepared by diet, purging, &c.; that the stramonium or belladonna be invariably used; that means be taken to subdue inflammation after the operation, and that the eye be not prematurely exposed to too strong a light. As a general rule, too, no operation should be undertaken so long as the patient enjoys the perfect sight of one eye.

SECTION XV.

Congenital Cataract.

THIS disease is more common than is generally imagined; indeed, many examples are recorded of all the children of a numerous family being born with cataracts in each eye. In the District of Columbia, there is a family of six children, all of whom are blind from congenital cataract. Sometimes only one eye is affected.

There is a peculiarity attending this disease which is seldom observed in common cataract—an extraordinary mobility or incessant rolling motion of the eye; that increases with the age of the patient, and is seldom, if an operation be long delayed, entirely gotten rid of. It is somewhat remarkable, also, that unlike ordinary cataract, the lens of the congenital variety, in most instances, is gradually absorbed, and the two capsules approach each other, and are at last identified, forming a tough elastic membrane. This fact was first particularly noticed by Saunders.

*Treatment of Congenital Cataract.*

Formerly, surgeons entertained the opinion that congenital cataract did not admit of relief until the patient attained the age of eight or ten years. Gibson of Manchester, and Saunders of Lon-

don, were among the first to correct this erroneous doctrine. Independently of the importance of an early operation, as respects education of the child, it is equally necessary to correct the mobility of the eye, and to guard against decay of the retina, which, for want of its natural exercise, is apt to fade and die.

For the removal of congenital cataract, I prefer, with the exception of the mode of securing the patient, the *anterior* operation as performed by Saunders, and described in the preceding section. Instead of four or five assistants to hold the child, some of whom must necessarily be in the way of the operator, I am inclined to recommend, from experience, the plan of Mr. Gibson, of Manchester, which is simply to enclose the body, arms, and legs of the patient in a bag open at each end, and furnished with tapes or strings to secure the limbs. Thus situated, the child may be laid on a large pillow placed on a table, and firmly held by one or two assistants. The operation may be performed, if necessary, on infants a month or six weeks old.

Before concluding the subject of cataract, it may be proper to state that the anterior capsule of the lens sometimes adheres to the iris, and occasions an immobility of the pupil. Under these circumstances, I should still prefer the *posterior* operation, and the use of the curve-pointed needle of Sir William Adams, (Plate VII. fig. 6,) taking especial care to be as gentle as possible in separating the adhesion, lest the iris be so injured as afterwards to cause obliterated pupil. It now and then happens, that after operations for cataract, (and operations, too, that have succeeded for a time,) secondary cataract is produced. This arises from capsular opacity. The posterior operation will, for this variety of the disease, also be found the most suitable.

SECTION XVI.

Amaurosis.

AMAUROSIS, gutta serena, or an insensible state of the retina, a disease of frequent occurrence, and always extremely difficult to cure, may be distinguished, generally, from other affections of the eye by the following symptoms. The pupil is of a greenish black colour, greatly expanded beyond its natural size, irregular in shape, and its edges undulating. When exposed to the strongest light, no perceptible contraction can be observed. Sometimes, however, instead of being dilated, it is unnaturally contracted. In other instances, the iris retains its sensibility so far as to be obedient to the stimulus of light, and contracts and dilates as usual, and yet the retina is completely insensible. In addition to these symptoms, the general aspect of the eye is peculiar, its natural lustre and intelligence are diminished or lost, and in bad cases of the disease, the patient is unable to direct his eyes steadily at any object, but turns them towards it obliquely. Most patients, in the incipency of the disease, are exceedingly annoyed by fantastic figures, called by most writers *muscæ volitantes*, which are constantly flitting before their eyes, especially when white and shining objects are looked at. Severe pain about the superciliary ridge and orbit is a frequent concomitant of the disease.

The *causes* of amaurosis are either local or constitutional. Among the former may be enumerated blows upon the head, wounds of the supra-orbitary nerve, exposure of the eye to vivid lights, long continued fatigue of the eye from examination of minute objects, the use of powerfully magnifying glasses, confinement in dark cells or dungeons, pressure upon the optic nerve from tumours, hydrocephalus, &c. The constitutional causes are derangement of the digestive organs, violent mental

emotions, suppression of accustomed or periodical discharges, immoderate venery, manstupration, excessive indulgence in opium and other narcotics, frequent attacks of syphilis, repeated mercurial courses, and a great variety of similar sources of excitement.

There is a singular variety of amaurosis, called hemeralopia, nyctalopia, or night blindness, in which patients see objects with perfect distinctness during the day, but lose their sight as soon as it becomes dark, remain blind throughout the night, and upon the approach of morning again recover their vision, which continues perfect until the return of evening. This disease sometimes arises without any evident cause; generally, however, it is endemic, and prevails to a greater extent in the East and West Indies than in other countries. Sometimes it appears to be hereditary; at least there are instances of whole families for several generations being subject to it. In Maryland there are now two distinct families in which the disease has existed from time immemorial. Persons having black eyes are said to be more subject to the complaint than others. When examined the eyes do not commonly exhibit any visible defect, except that the pupil is unusually large, and less moveable than natural.

Treatment of Amaurosis.

This must depend in a great measure upon the cause of the disease. When it arises from any organic defect, and from most of the local causes above enumerated, there will be very little probability of affording permanent relief. If it proceed from gastric derangement, or from passions of the mind, emetics and purgatives will prove the most useful remedies, and after full benefit has been derived from these, tonics may be resorted to.

For *hemeralopia*, repeated purgatives and a succession of blisters to the temples, are highly recommended by Mr. Bamfield,* the most experienced writer on this subject.

* Medico-Chirurg. Transactions, vol. 5.

SECTION XVII.

Hordeolum.

THE hordeolum, or sty, is a red, inflamed, and painful tumour involving one or more of the meibomian glands. It is similar, in many respects, to the common furuncle or bile, met with in other parts of the body, and is usually seated upon the lower eyelid near its inner angle. The disease is very common, and arises, for the most part, from some disordered action of the stomach. Like the furuncle, it seldom terminates in suppuration.

*Treatment of Hordeolum.*

Purgative medicines and attention to diet will often, without the aid of local applications, remove hordeolum. When the tumour, however, continues stationary for some time, and is painful, an attempt should be made, by warm emollient applications, to excite suppuration in the cellular membrane surrounding it. By these means we sometimes succeed in detaching the core or slough that occupies the centre of the tumour, after which the opening left will soon heal. When the inflammation has subsided, and the tumour becomes indolent, the application of lunar caustic or of nitric acid will frequently effect a cure.

SECTION XVIII.

Encysted Tumours of the Eyelids.

STEATOMATOUS and melicerous tumours, from the size of a pea, to that of a large bean, are frequently met with beneath the conjunctiva, or imbedded in the substance of the eyelid. They are, generally, soft, devoid of pain, and roll under the finger. The upper eyelid is the most common seat of the disease. When the tumour attains a very large size, it is liable to interfere with vision, or it may produce eversion and other diseases of the eyelids.

*Treatment of Encysted Tumours of the Eyelids.*

Extirpation is the only remedy, and this, when the tumour has acquired a moderate size, is easily accomplished, especially when it is seated on the inside of the lid immediately beneath the conjunctiva. The surgeon everts the lid with his finger, secures the tumour by a fine hook, then makes an incision with a diminutive scalpel over its surface parallel with the eyelid. As soon as the external covering is fairly divided, the tumour is easily loosened from its bed, and by a few strokes of the knife or scissors entirely removed. When it is deeply seated within the substance of the orbicular muscle, or lies exterior to it, the operator will find it most convenient to extract the tumour by cutting through the lid on its outer side—taking care to separate the muscular fibres longitudinally.

SECTION XIX.

Entropeon.

By the term entropeon is understood an inversion of the tarsus, or its cilia. *Trichiasis* is also used to denote the same disease. The upper eyelid is commonly the seat of entropeon, which, in proportion to its duration and the extent of the inversion, is productive of more or less irritation by encroaching upon the ball of the eye. In general, the entropeon proceeds from protracted ophthalmia, or psorophthalmia, and from other causes capable of producing a morbid inclination of the tarsus, or a wrong direction of the cilia.

*Treatment of Entropeon.*

An evulsion of the eyelashes by a pair of fine forceps or tweezers, when the entropeon depends upon their unnatural position, is the only remedy calculated to remove the complaint, and this does not succeed always. For inversion of the tarsus itself, several different operations have been practised. In simple cases, especially where the disease appears to be owing to inordinate relaxation of the skin of the eyelid, the removal of an oval portion of this superfluous skin by the forceps and curved scissors will generally effect a cure, provided the surgeon take care to cut as closely as possible to the tarsus, and afterwards draw the edges of the wound together by a fine suture. The

cicatrix that ensues will afterwards prevent the tarsus from falling inwards upon the globe of the eye. But this operation does not commonly answer for cases of long standing. Mr. Crampton, an ingenious Irish surgeon, has proposed to dissect off the thickened conjunctiva, which he conceives to be the most common cause of entropeon. On the other hand, Mr. Saunders and Dr. Dorsey advise the entire or partial removal of the tarsus. I have, however, tried these different operations, and have found them painful and difficult, and not always successful. I am inclined to think more favourably of an operation lately proposed by Dr. Jæger of Vienna, though I have had no opportunity of testing its merits. This surgeon, instead of removing the whole tarsus, merely dissects off its anterior edge, and along with it the cilia, thereby removing a considerable source of irritation, at the same time preserving that portion of the cartilage which serves to guide the tears towards the puncta lacrymalia.

SECTION XX.

Ectropeon.

THE ectropeon is the reverse of the entropeon—the eyelid being turned outwards instead of inwards. Sometimes both the upper and lower eyelids are simultaneously affected, but in most instances the lower lid is the seat of the disease. Like the entropeon, it may proceed from repeated and long continued attacks of ophthalmia, and in such cases the conjunctiva lining the lid is generally thickened or in a fungous state. Occasionally, the ectropeon arises from burns or wounds in the neighbourhood of the eyelids, the cicatrices of which, by contracting and distorting the tarsus, evert the lid and expose its inner surface. In all cases of the kind, the deformity arising from the red and exposed surface of the conjunctiva is considerable, and the irritation to the globe of the eye such as not unfrequently to produce opacity or ulceration of the cornea.

Treatment of Ectropeon.

Excision of the fungous conjunctiva, and the application of various caustics, have been advised by most writers. The only operation, however, likely to afford permanent relief is that practised by Sir William Adams. It is performed in the following way. A portion of the lid, in the shape of the letter V, is removed from the outer angle of the eye by a pair of straight sharp scissors. The thickened conjunctiva is next carefully

dissected off, when there will be no obstacle left in most cases to the replacement of the lid. To retain it in its situation and to promote adhesion, a fine interrupted suture should be passed through the edges of the wound, and supported by a compress. The size of the portion to be removed must depend upon the extent of the eversion, &c. It needs hardly be mentioned that the base of the triangular incision should look towards the edge of the tarsus. When the ectropeon depends upon a cicatrix, from loss of substance near the lid or from a burn, it may become necessary to make an incision parallel with the lid through the contracted integuments, and afterwards interpose lint to prevent their reunion. But the operation seldom succeeds perfectly.

SECTION XXI.

Fistula Lacrymalis.

EPIPHORA or stillicidium lacrymarum, and fistula lacrymalis, have been used by some writers indiscriminately to denote the same disease; by others they have been looked upon as essentially distinct; they may, however, I conceive, be ranked with propriety as varieties or stages of the same complaint; but it by no means follows that every epiphora must necessarily terminate in fistula lacrymalis, although fistula lacrymalis may be said to be preceded invariably by epiphora.

Epiphora may arise from several different causes—from an undue secretion of tears—from closure of the puncta lacrymalia or obliteration of the canaliculi lacrymales—from inflammation of the lacrymal sac, and from stricture of the nasal duct. These in their turn may be the result of other agents, especially of the different varieties of ophthalmia, &c.

When the puncta lacrymalia are closed, the tears constantly flow over the lids, and spreading upon the cornea, produce a morbid refraction of light, which obliges the patient constantly to wipe them away. On the contrary, when the nasal duct is obstructed, the tears accumulate in the sac, and form a tumour immediately below the tendon of the orbicular muscle; and upon pressing this tumour, the tears regurgitate through the puncta mixed with flocculent matter. So long as the disease continues in this state, the terms epiphora, and stillicidium lacrymarum, are strictly applicable to it. Should the sac, however, inflame and ulcerate, and an opening be established between it and the integuments, then a fistula lacrymalis is produced. In such cases the inflammation generally extends to the globe of the eye, and in some instances to the side of the face and head. If neglected, the disease may continue for months or years, or indeed

during the patient's life, sometimes better, sometimes worse, and in the end may be followed by caries of the unguis, and injury of the æthmoid and spongy bones.

Treatment of Fistula Lacrymalis.

A simple epiphora, dependent upon obstruction of the nasal duct, or, as sometimes happens, upon a morbid secretion from the meibomian glands, may be generally removed by the repeated introduction of Anel's probes into the puncta and duct, and by the application of the unguentum hydrargyri nitrati, and other astringent ointments, and washes to the lids and edges of the tarsus. After the obstruction has been overcome by the probes, the passages should be syringed out two or three times a day, taking care to introduce the curved pipe of the syringe into the lower punctum, and, at the same time, with the point of a finger to stop the upper punctum, and thereby prevent the regurgitation of the fluid. Tepid water, at first, and afterwards a weak solution of the sulphate of zinc or acetate of lead, will be found the most suitable wash. When the epiphora depends upon obliteration of the puncta or canaliculi lacrymales, the disease may be considered incurable.

Fistula lacrymalis can be removed only by overcoming the obstruction in the nasal duct, or by establishing a new route for the tears through a perforation of the unguis. The first mode should, if practicable, be always resorted to. The surgeon introducing into the fistulous orifice a common pocket case probe, carries it, at first, horizontally, until it is fairly introduced into the cavity of the lacrymal sac; the handle of the instrument is then raised, and made to rest nearly in a perpendicular direction against the superciliary ridge, while the point is directed downwards in the course of the duct, and pressed firmly but steadily against the stricture. As soon as this is overcome, the probe passes easily into the nose, and a few drops of blood and

matter issue from the nostril of the affected side. The probe is then withdrawn, and a silver style, (an instrument resembling in shape and size the probe, but only an inch and a quarter in length, and having a head obliquely placed upon its top) introduced in its place. This is permitted to remain in the passage, and serves the purpose of conducting the tears by a sort of capillary attraction into the nostril. In the mean time, the fistulous orifice gradually contracts around the neck of the instrument, the head of which afterwards prevents it from falling into the nose. Occasionally, the style should be withdrawn, and the passage syringed out. Some patients find it necessary to wear the style several months, others are cured by it in a few weeks. Where the fistulous orifice is so small that the probe will not enter, it should be enlarged by a spear-pointed lancet. Sometimes it is necessary to make an opening into the sac, where the fistula is not properly situated, or does not exist. Under these circumstances, the surgeon should always take as his guide, the small tendon of the orbicularis, and immediately beneath this make his incision.

If, as sometimes happens, the nasal duct be permanently closed by stricture, or by an exostosis from the surrounding bony canal, it will become necessary to perforate the os unguis. This can be most conveniently done by the perforator of Cruikshank, (an instrument resembling, in some respects, the shoemaker's punch,) which is carried through both sides of the lacrymal sac, and made to bear upon the inferior part of the unguis. To prevent the instrument from passing too far inwards, a narrow piece of horn should be carried up the nostril, and upon this, the perforator will rest and perform its office with great facility. After the opening has been made through the sac and bone, a silver or leaden style, somewhat shorter than that used for the natural duct, should be introduced and worn as long as may be found necessary. When the operation is properly performed, the opening will always be made between the superior and inferior spongy bones.

There are other operations practised for the cure of fistula lacrymalis, but they seldom prove so effectual as those I have described.

On Diseases of the Eye, consult—*Scarpa's Practical Observations on the Principal Diseases of the Eyes*, translated from the Italian, with Notes, by James Briggs, 2d edit.—*Ware's Chirurgical Observations relative to the Eye*, in 2 vols. 8vo.—*Wardrop's Essays on the Morbid Anatomy of the Human Eye*, in 2 vols. 8vo. Edinburgh, 1808 and 1818—*Vetch's Practical Treatise on the Diseases of the Eye*, 1820—*Travers' Synopsis of the Diseases of the Eye, and their Treatment*, 1820—*A Treatise on some Practical Points relating to the Diseases of the Eye*, by the late John Cunningham Saunders, 8vo. 1811—*Practical Observations on Entropion, or Eversion of the Eyelids, with the Description of a new Operation for the Cure of that Disease; on the Modes of Forming an Artificial Pupil, and on Cataract*, by William Adams, 8vo. 1812—*An Essay on the Entropion*, by Philip Crampton, M. D. London, 1806—*Wenzel's Treatise on Cataract*, by Ware, 1791—*Pott's Remarks on Cataract*, in third vol. of his *Chirurgical Works*—*Hey's Practical Observations in Surgery—A Practical Inquiry into the Causes of the frequent Failure of the Operations of Depression, and of the Extraction of the Cataract as usually performed, with the Description of a Series of New and Improved Operations, &c.* by Sir William Adams, 8vo. 1817—*Practical Observations on the Formation of an Artificial Pupil, and Remarks on the Extraction of Soft Cataracts*, by Benjamin Gibson, 8vo. 1811—*A Treatise on the Diseases of the Eye, including the Doctrines and Practice of the most eminent modern Surgeons, and particularly those of Professor Beer*, by George Frick, M. D. 8vo. 1823—*A Practical Treatise on the Diseases of the Eye*, by William Mackenzie, 8vo. London, 1830—*A Treatise on the Venereal Diseases of the Eye*, by William Lawrence. London, 1830—*Lectures on the Operative Surgery of the Eye*, by J. G. Guthrie. London, 1827. 8vo.

CHAPTER XI.

DISEASES OF THE EAR.

FROM the complex structure and diminutive form of the auditory organs, the older surgeons always despaired of arriving at any certain knowledge of the nature and treatment of their diseases. Hence, all the information we possess on the subject, may be considered, comparatively, of modern origin. Still we are much in the dark, and may, perhaps, for ever continue so, respecting many affections, especially those of the internal ear. For these very reasons, however, the student, instead of neglecting, as is too common, the anatomy of the ear, under the impression that he can never acquire an accurate knowledge of it, should strive to make himself minutely acquainted with its most intricate structure, as the only means of understanding its diseases, which after all are not in reality so complicated and obscure, as is commonly imagined. Much assistance, also, may be obtained from a simple and accurate classification of these diseases—such as I shall endeavour to present in the ensuing sections.

SECTION I.

Diseases of the External Ear, and Meatus Auditorius.

THE external ear may be separated from the head by a sabre cut, or by a cannon ball, or it may be bitten off. It is sometimes frost-bitten, and sloughs away; at other times, it is destroyed by ulceration. Formerly, it was supposed that such accidents or diseases would necessarily be followed by loss of hearing; but experience proves the reverse; indeed, cases are recorded of patients born without external ears, who, nevertheless, enjoyed to a certain extent the sense of hearing. Of the individual parts of the ear, the lobe is the most subject to disease. In several instances, I have known sarcomatous tumours to spring from it—in shape resembling the vegetable called prickly pear—which have sometimes attained a large size. In all these cases, the disease was met with in negroes, and seemed to originate from brass ear-rings worn by the patients. Encysted or steatomatous tumours of the lobe are very common. They generally occupy the centre, and seldom increase beyond the size of a pea.

The *meatus auditorius* is liable to accidents and to diseases. Extraneous bodies, such as peas, stones, glass beads, pieces of slate pencil, cherry stones, bits of wood or metal, are frequently put into the ear by children; and by lodging at the bottom of the meatus, or upon the membrana tympani, excite irritation or suppuration. Sometimes insects find their way into this passage, and produce great alarm to the patient, as well as pain. Worms, also, may be generated within the meatus, in consequence of the eggs from which they are produced, having been deposited by flies during the patient's sleep. At other times, worms creep into the ear, as in the following instance. Several

years ago, a poor woman, the wife of a skin dresser, brought her child to me, stating that a few days before, the child had been playing with its companions on a pile of sheep's wool that lay in the yard; and that in a few minutes after, he complained of uneasiness in the ear, which was soon followed by violent ear-ache, and subsequently by suppuration. To relieve the pain and check the discharge, the mother poured sweet oil into the ear, and in a few moments, to her great surprise and horror, observed a worm make its appearance near the surface, but upon attempting to seize it, it immediately retired beyond her sight and reach. Scarcely giving credit to the woman's statement, I repeated the experiment with the oil, and in a few seconds the worm appeared, its approach being preceded by several bubbles of air passing through the oil. I tried instantly to secure it with a pair of slender forceps, but with great dexterity it eluded the grasp, and made its escape. Several times the attempt was repeated, and at last, with success. When placed on the table, the animal was found three-quarters of an inch long, about as thick as a common piece of twine, black about the head, and white on the rest of its body. It was extremely active, and appeared very tenacious of life. The woman immediately recognised it as a species of worm very commonly met with amongst new-shorn wool, and had no doubt that it had found its way into the boy's ear at the time he was playing on the pile. Cases, in some respects, similar to this, are recorded by Acrell, Valsalva, Morgagni, and others.

The *cerumen*, or wax of the ear, often accumulates in undue quantity, and forms an inspissated mass, which may interrupt or destroy the hearing.

Suppuration of the lining membrane of the meatus auditorius, is a very common affection, especially amongst infants and young children, in whom it arises from cold, want of cleanliness, &c. When the discharge is profuse and long continued, it becomes, particularly during warm weather, very offensive, and, if not checked, may eventually destroy the membrana tympani and small bones of the ear.

Polypi of the meatus, are occasionally met with. They spring from the bottom of the passage, or from the sides of the membrane. In either case, they generally increase until they

fill up the whole cavity, and project beyond the orifice, so as to render the patient partially or entirely deaf.

An *herpetic eruption* is another complaint to which this passage is subject. It is rather frequent than otherwise, and occurs chiefly in scrofulous patients. The discharge from the sore is extremely offensive, and sometimes so profuse, thick and viscid, as to block up the passage. Occasionally, the eruption extends beyond the meatus, and affects the external ear.

Children are sometimes, though very rarely, born with the meatus auditorius imperfect. This may proceed from a thin membrane covering the orifice of the passage, or seated some distance within it, or from the whole tube being filled up by a tumour, or by a coalescence of its sides.



Treatment of the Diseases of the External Ear, &c.

For sarcomatous tumours of the lobe of the ear, there is no other remedy than excision, and this commonly succeeds. Encysted, or steatomatous, tumours, if they attain a sufficient size to produce deformity, or to become troublesome, may be dissected out in the same manner that they are removed from other parts of the body.

Extraneous bodies introduced into the meatus auditorius, if attended to before they excite inflammation and swelling, may generally be removed by a pair of very slender forceps. Beads, cherry stones, and shot, however, are always difficult to seize, on account of their round form and smooth surface. Upon one occasion, after having ineffectually tried to extract a pea from the ear of a child by the forceps, I succeeded in splitting it with a couching needle, and then removed the pieces without difficulty, by throwing in a stream of water from a syringe. A bent probe will sometimes answer a better purpose in the removal of an extraneous body than any other instrument. Insects

that find their way into the meatus, or are generated in the passage, are easily gotten rid of by pouring olive or any other mild oil into the ear. The oil obstructs the pores of their respiratory apparatus and obliges them to come to the surface. They may also be destroyed by the smoke or infusion of tobacco, or by other stimulating articles. *Hardened wax* is easily removed by the repeated use of the syringe and ear-pick. Warm water, or soap and water, are the best solvents for this wax.

Suppuration of the lining membrane of the meatus auditorius may be relieved or removed, in most instances, by antiphlogistic remedies, and by moderately astringent injections, provided the disease is attended to in its commencement. The passage should be protected during cold weather by a dossil of wool introduced into its orifice.

In scrofulous children it is not uncommon to meet with offensive discharges from the ear, which have continued for years. In all such cases I have derived great benefit, and sometimes effected perfect cures, by fumigating the passages with æthiops mineral. A small portion of the powder may be strewed on a heated iron and held close to the ear, or the fumes may be conveyed more accurately to the part by collecting them in a tin vessel resembling an ear trumpet. The operation should be repeated two or three times a-day.

Polypi of the ear, if not too deeply situated, may be extracted by slender forceps; but the operation is a delicate one and requires considerable skill. The ligature recommended by some surgeons, cannot be employed with advantage. The application of lunar caustic is sometimes rendered necessary to destroy the remnants of the disease.

For the removal of *herpetic* eruptions, mercurial preparations are the most serviceable, especially the internal use of calomel, and a weak solution of corrosive sublimate, as an injection.

The *imperforate* meatus auditorius has sometimes been restored by dividing the membrane which blocks up the passage, and afterwards wearing a tent to keep it from closing. When the sides of the tube are firmly united, and all remains of the original meatus obliterated, an operation will seldom prove successful.

SECTION II.

Diseases of the Tympanum, and Eustachian Tube.

Otalgia or ear-ache, a very common, and sometimes most severe affection, is generally the result of acute inflammation of the membrane lining the cavity of the tympanum. The pain is excessive, and extends, in many instances, from the ear to other parts of the head, accompanied by fever and delirium. If these symptoms continue for any length of time, suppuration is almost sure to ensue, and matter collects not only in the cavity of the tympanum, but in the mastoid cells and Eustachian tube. This matter is generally ichorous and sometimes sanious. When copiously secreted, it destroys by pressure the membrana tympani, and is discharged at the meatus externus, not unfrequently along with one or more of the small bones that occupy the tympanum. From this cause, and from obliteration of the Eustachian tube by inflammation, permanent deafness is extremely apt to follow. Caries, too, of the tympanum and mastoid cells, complicated with fungus, is a frequent consequence of this distressing disease.

The *Eustachian tube* is frequently closed, independently of any affection of the tympanum, from the sloughing or ulceration which sometimes follows cynanche maligna, scarlet fever, cynanche tonsillaris, syphilis, the immoderate use of mercury, &c. In all such cases, partial deafness ensues, owing to the air within the tympanum being confined, or absorbed, or to the cavity being filled by mucus. The membrana tympani, in either event, is incapable of the requisite degree of vibration, and the patient's hearing is thereby rendered very indistinct, or entirely destroyed. It is not always easy to discriminate between this variety of deafness and that proceeding from other causes.

Much information may be gained, however, from accurate inquiries into the history of the complaint, and by directing the patient to close the nostrils and mouth, and blow forcibly with his breath, which, if the Eustachian tube be closed, will not enter the cavity of the tympanum and communicate an impulse to its membrane or drum, as generally happens when the guttural extremity of the tube is pervious. Moreover, patients deaf from closure of the Eustachian tube, are seldom disturbed by those unpleasant sounds in the ear which so commonly accompany nervous deafness.

Treatment of Diseases of the Tympanum, &c.

A most absurd and highly pernicious practice is frequently pursued in the treatment of inflammation of the membrane lining the tympanum—that of pouring stimulating or acrid fluids into the meatus externus, with a view of relieving the intense pain accompanying the disease. Instead of this, general and topical blood-letting, purging, blistering, &c., in the commencement of the disease, are the proper remedies. If by these means suppuration be not prevented, and the matter is rapidly accumulating, the surgeon, without delay, should make a small opening with a sharp-pointed probe or couching needle in the membrana tympani, and evacuate the matter; otherwise, the whole of this membrane may be destroyed by ulceration, the ossicula discharged, and the hearing irrecoverably lost. After the inflammation has subsided, astringent injections may be employed to correct and suppress the discharge. If fungous or polypous excrescences sprout from the tympanum and fill up the meatus, they should be removed by the forceps and lunar caustic.

For the relief of deafness arising from obliteration of the Eustachian tube, an ingenious expedient was suggested, long ago, by Chesselden, and afterwards practised by Sir Astley Cooper—the perforation of the membrana tympani. This operation, as

was correctly imagined, served the purpose of admitting the external air to the tympanum, and thereby, for a time, restored the patient's hearing. It was soon found, however, in most instances, that the benefit was temporary—owing to the inflammation excited by the puncture, producing an induration of the membrane, and a consequent loss of vibratory power. The opening in the membrana tympani, in other cases, moreover, was found to close speedily after the operation. For these and some other reasons, the operation is now seldom practised. Should it ever become necessary to resort to it, a small sharp-pointed probe will answer all the purposes of the regular and more complicated instruments—care being taken to select such cases of deafness only, as are dependent upon closure of the tube, and, in performing the operation, to avoid perforating that part of the membrane to which the handle of the malleus is attached.

Some of the English and French surgeons have contrived instruments for cleansing the Eustachian tube, when clogged with mucus or extraneous bodies. The difficulty, however, of introducing the pipe of a syringe or probe into the guttural extremity of this passage, has deterred most persons from attempting the operation.

SECTION III.

Diseases of the Internal Ear.

THAT variety of deafness, usually called *nervous*, is exceedingly common, and arises, for the most part, from some organic defect, or change in the structure of the auditory nerve. The membrane, also, upon which the nerve is expanded, and the fluid which it contains, may undergo such alterations as render them unfit to perform their proper functions, and from these causes there is reason to believe that nervous deafness frequently proceeds. So far as inferences can be drawn, from the appearances presented upon dissection, the following circumstances may be enumerated as likely to interfere materially with the sense of hearing: 1st. An unusual hardness of the auditory nerve; 2dly, a diminution of the nerve; 3dly, a thickening of the membrane of the labyrinth; 4thly, the formation of a steatomatous or caseous substance within the cavity of the vestibule; 5thly, calcareous matter in the vestibule; 6thly, malformation of the vestibule, semicircular canals, and cochlea. If, from these or other causes, nervous deafness should arise, it will be indicated, in most instances, by tinnitus aurium, or ringing in the ears, by unpleasant and peculiar sounds resembling the dashing of waves, the murmuring of bees, the roaring of a cataract or water-fall, the hissing of a tea-pot, the rustling of leaves, the singing of a conch or shell, the vibration of the stethoscope, and many other strange, and, to the patient, unaccountable noises. These symptoms are most urgent during the winter, at night, and in cloudy weather, and whenever the patient has taken cold. Most patients, indeed, troubled with nervous deafness, are peculiarly susceptible of cold; from this, and from other causes, there is a diminution of the ceruminous secretion, and, consequently, a peculiar dryness or huskiness of the meatus auditorius. Despondency is a frequent concomitant of nervous deafness. Children, totally deaf, at birth, from some permanent organic defect of the internal ear, necessarily remain dumb.

Treatment of Diseases of the Internal Ear.

For confirmed nervous deafness, unfortunately, there is no remedy, though much may be done towards arresting the progress of the disease whilst in the commencement. The chief indication, generally, is to reduce the patient by blood-letting, purging, and low diet; after which a blister behind the ear, or a succession of blisters, will often prove highly beneficial. In addition to this treatment, the patient should be directed to guard, carefully, against cold or exposure, by protecting the feet, wearing in other respects suitable clothing, avoiding a current of air, &c. The free use of common salt applied to the skin, or rubbed among the hair of the head, will be found to contribute very much to this end, and is frequently prescribed by Dr. Physick in cases of nervous deafness accompanied by great susceptibility of cold. Nervous deafness from syphilis is by no means uncommon, and may generally be removed radically by a course of mercury. In many incurable cases of deafness, the patients derive great assistance from the use of ear trumpets, one of which, lately invented in France, in the shape of a flexible tube, eighteen or twenty inches long, has been extremely useful, and far superior to any instrument of the kind ever invented.

See *The Anatomy of the Human Ear, illustrated by a Series of Engravings, of the natural Size; with a Treatise on the Diseases of that Organ, the Causes of Deafness, and their proper Treatment, by the late John Cunningham Saunders, 8vo. 1817—A Treatise on the Physiology and Diseases of the Ear; containing a Comparative View of its Structure and Functions, and of its various Diseases, &c., by John Harrison Curtis, 8vo. 1817—An Essay on the Human Ear, its Anatomical Structure and incidental Complaints, &c., by W. Wright, 8vo. 1817—Observations on the Effects which take place from the Destruction of the Membrana Tympani of the Ear, by Astley Cooper, 4to. 1800—Further Observations on the Effects which take place from the Destruction of the Membrana Tympani, with an Account of an Operation for the Removal of a particular Species of Deafness, by Astley Cooper, 4to. 1801—Richerand's Nosographie Chirurgicale, ou Nouveaux Elemens de Pathologie, tom. 2, p. 135—Dictionnaire des Sciences Medicales, tom. 38, p. 24, article Oreille—Rosenthal, Essai d'une Pathologie de l'Organe de l'Ouïe, in Journ. Complement. du Dict. des Sciences Med. tom. 6—Memoire sur la Theorie des Maladies de l'Oreille, et sur les moyens que la Chirurgie peut employer pour leur curation, par M. Leschevin; in Memoires sur les Sujets proposes pour le Prix de L'Academie Royale de Chirurgie, tom. 9, p. 111, Edit. duodec.*

CHAPTER XII.

DISEASES OF THE ARTERIES.

THE arteries, like most other textures, are supplied with blood-vessels, nerves, exhalents and absorbents, and are made up of coats or coverings, differing from each other in structure, consistence and tenacity. Hence, they are subject to many diseases to which other soft parts are liable; whilst, at the same time, they possess powers of resisting disease peculiar to themselves. To understand their diseases, an accurate knowledge of their structure and conformation is very necessary—though the study is commonly much neglected by students.

There are three coats to an artery—an external, middle, and internal coat. The external coat is composed of condensed cellular membrane, is remarkably elastic and tough, of a pure white colour, smooth on its inner surface, and rough on its outer, where it is in contact with a cellular sheath or an additional investment. The *middle* coat is uncommonly thick, and appears to consist of muscular fibres arranged in a circular direction. There is every reason to believe, however, that these fibres are not muscular, for they are compact and solid, but they readily break; whereas, muscular fibres are soft, and bear extension, and are with difficulty broken. In several other respects, also, these fibres differ from the muscular and approach to the fibrous texture. The third, or *internal* coat, is remarkable for its extreme delicacy, and is so exceedingly thin as to appear nearly transparent. It is of a very white colour, and its internal surface has an unctuous feel. Externally it is connected

slightly to the middle coat, though not by intermediate cellular membrane. Notwithstanding the tenuity of this coat, it is possessed of considerable strength longitudinally, but tears readily when force is applied in the circular direction.

The *vasa vasorum*, with which all arteries are supplied, are commonly derived from the adjoining trunks or branches. They first penetrate the cellular coat, upon which they are abundantly distributed, then send numerous ramifications to the surface throughout the substance of the middle coat, and finally terminate, there is no reason to believe, upon the inner surface of the third coat. According to Bichat,* however, these vessels do not reach the internal coat; but, as this coat is evidently vascular, as may be distinctly seen after careful maceration, the supply of blood is probably derived from the *vasa vasorum*, and perhaps also from some other source.

Arteries are subject to inflammation, suppuration, ulceration and sphacelus. They are also liable to have their texture subverted by the formation of calcareous concretions, by uniform enlargement or dilatation of their different coats, or by rupture of the internal and middle coats, in which latter case the disease *properly* termed *aneurism* is produced.

The internal coat is more subject to inflammation than either the middle or external coat. This is evinced by the effusion of lymph, which is often poured out in large quantity upon the inner surface of an artery, in consequence of inflammation of contiguous parts, from the application of ligatures, from wounds, from the pressure of tumours, and from many other similar causes. Sometimes the inflammation thus excited travels along the vessels as far as the heart, and proves fatal. Chronic inflammation of the arteries is frequently met with, and is very apt to follow or precede calcareous depositions. An appearance similar to that produced by inflammation is often presented upon the internal surface of arteries—a vivid redness or scarlet tinge. This is not, however, always the result of inflammatory action, for it is seldom accompanied by an effusion of lymph. Arteries, likewise, that have been exposed for a few days to the air in the dissecting room, invariably assume the same colour.

* General Anatomy, translated by Hayward, vol. i. p. 317.

Although arteries resist for a long time the *ulcerative* action, they are liable eventually to be destroyed. So long, however, as they continue *sound*, the risk of ulceration is diminished; hence the process rarely takes place except in arteries that have been tied by ligatures of an improper form or size, or have been compressed by blood, which has injected the cellular membrane around the vessel and destroyed its vasa vasorum, and thereby deprived it of its nourishment. Ossified arteries, also, as they are called, sometimes ulcerate and give rise either to hemorrhage or to aneurism. Extensive ill-conditioned ulcers, by penetrating deeply and laying waste the soft parts, may occasion fatal hemorrhage by opening large arteries.

It is unusual for arteries to mortify and slough, and when the process does take place, it is seldom followed by hemorrhage; for during the progress of the mortification among the surrounding parts, the vessels become filled with coagula to a considerable extent, which seal their extremities for a time and prevent hemorrhage: these coagula are afterwards absorbed, and the mouths of the vessels permanently closed, through the medium of adhesive inflammation.

But the most common disease of arterial trunks and branches is the deposition of *calcareous* matter. So common, indeed, is this condition of the arteries in the advanced periods of life, that the vessels of few old subjects are exempt from it. It is not peculiar, however, to old age, but has been occasionally met with even in the arteries of infants. The *outer* surface of the internal coat is the most frequent seat of the calcareous deposite. From this surface it extends gradually through the coat and projects into the area of the vessel, being for a time still covered with a fine pellicle or membrane. At last this membrane gives way, and the concretion is then brought in contact with the blood. It is seldom that we find an artery completely incrustated with this earthy matter, so as to form an entire rigid cylinder; the depositions, on the contrary, are scattered in irregular patches, varying in shape, number, and size, over the surface, and throughout the substance of the internal coat. Sometimes they are intermixed with a curdy, pultaceous, or steatomatous matter. It is this condition of an artery which generally lays the foundation of aneurism, as will hereafter be explained: from this cause, also, it often happens, that arteries are unable to bear the opera-

tion of the ligature, which, when applied, either produces rupture of the vessel or excites ulceration. There are several other diseases, moreover, that seem to result from this earthy degeneration of the arterial tubes.

A uniform dilatation of the arterial coats is not so unfrequent as some modern writers have imagined; and although distinct in many respects from aneurism, is often conjoined, or exists simultaneously, with that disease. From aneurism, however, it differs chiefly in the circumstance of the vessel being enlarged throughout its circumference—whereas, in aneurism, the dilatation is commonly on one side. Besides this, a dilated artery seldom, if ever, contains a coagulum, which an aneurismatic artery always does. The larger arteries are most subject to dilatation; hence, the disease is very common in the aorta; also, where vessels divide, or where they form angles, dilatation is very apt to ensue. From this cause the arch of the aorta, the iliacs and carotids at their division are oftentimes greatly expanded beyond the natural size. Very urgent symptoms, and even fatal consequences, not unfrequently follow an enlargement of the great vessels in the vicinity of the heart.

SECTION I.

Aneurism.

ANEURISM has been defined "a pulsating tumour formed of arterial blood;"* and to this there can be no valid objection, provided the explication be restricted to the form of the disease usually met with. Different appellations, also, have been given to certain varieties of the disease—such as true and false, circumscribed and diffused. Again—we have varicose aneurism, and aneurism by anastomosis. By the term *true* aneurism, is commonly understood a simple dilatation of all the coats of an artery—by *false* aneurism, a rupture or wound of the three coats, so that the blood is extravasated among the surrounding parts. The terms *circumscribed* and *diffused*, relate merely to the form of the swelling or the extent of the extravasation. I shall deviate so far from common authority, as to restrict the meaning of *true* aneurism to that condition of an artery in which all its coats are uniformly dilated, or else the internal and middle coats ruptured while the cellular coat remains entire. By *false* aneurism, I understand that arising from a wound or division of an artery. *Varicose* aneurism, and aneurism by *anastomosis*, will be noticed hereafter.

In the incipient stage of aneurism, the tumour is small, free from pain, and easily made to disappear by pressure; but returns as soon as the pressure is discontinued. For a long time the skin preserves its natural colour; as the swelling augments, however, it becomes pale, and œdematous. The strength of the pulsation in the tumour, is greater during the early than the advanced stages of the disease; for in proportion as the swelling

* C. Bell's Operative Surgery, vol. i. p. 70.

augments, the coagulated blood which fills the sac is interposed in such a way as to diminish the stroke of the artery in which the aneurism is seated. When the tumour attains a large bulk, the integuments covering it become painful and livid, and crack in different places; through the fissures a bloody serum is distilled, ulceration follows, which, extending to the sac, opens a communication with its cavity, from which fluid blood issues in a stream, mixed with coagula; as the ulceration extends, the opening enlarges, the hemorrhage becomes more and more frequent, and, if not arrested, destroys the patient. Sometimes the tumour, by pressing upon a contiguous bone, causes its removal; this is effected through the medium of the absorbents: the bone, however, is not rendered carious, nor does the formation of pus accompany the process.

Disputes have arisen, at different periods, respecting the formation of aneurism, or the mode by which the disease is induced—some contending that there is a uniform dilatation of the three coats—others, that the internal and middle coats are ruptured or ulcerated, and the tumour formed by a distention of the external or cellular coat. Both opinions seem to be well founded, and the error committed, as correctly remarked by Hodgson, appears to have been, that the advocates for each doctrine took too limited a view of the subject. There can be no question, however, I think, that the theory broached by Senertus, and supported with so much ingenuity by Scarpa, will be found to afford the true explanation of the phenomena usually met with in the generality of aneurismal tumours—that the internal and middle coats are ruptured or destroyed, and that the sac is formed by a dilatation of the external coat. In proof of this being the true explanation, it will only be necessary to state, that in most aneurisms the tumour will be found upon dissection to occupy one side of the artery, whereas, if all the coats were regularly dilated, it should embrace the whole circumference of the vessel. Again—if a careful separation of the different coats be made, the external coat may be traced throughout, while the internal and middle coats, at the place where the entrance of the aneurismal sac communicates with the artery, will be perceived to terminate by an abrupt or fringed margin. On the other hand, there can be no doubt whatever, that a regularly dilated artery, and such as is commonly considered an aneu-

rismal artery, is sometimes met with, independently of a rupture of the internal coats, that, in other instances, these coats, after having expanded to a certain extent, ulcerate or are ruptured and give rise to the common form of the disease—the latter being thus ingrafted, as it were, upon the former. It must not be supposed, however, from these observations, that every dilated artery can be considered an aneurismal artery, for there are many instances to the contrary. The arteries, for example, of the impregnated uterus, become greatly enlarged beyond their natural size; the collateral branches, also, after a main trunk is tied, are dilated in a similar manner. The distinction, then, should be drawn between the dilatation of a sound and a diseased artery; and, perhaps, it may with propriety be stated, that *true* aneurism is never produced without a previous morbid condition of the coats of the vessel in which it is seated. This morbid change of structure has been already noticed, as connected with calcareous deposition, or with the formation of atheromatous matter between the internal or middle coats. Arteries thus situated are very liable to give way even under ordinary muscular exertion; hence, in nine cases out of ten, external aneurism is the result of sudden and violent extension or flexion of a limb, while the internal is produced by lifting heavy weights, &c.

False aneurism differs essentially from the true, inasmuch as the blood is not contained within the entire walls of the artery, or within its cellular coat, but poured into the cellular membrane adjoining the wounded vessel, where it is either confined within a narrow space, or else spread over an extensive surface—hence the origin of the terms *circumscribed* and *diffused* aneurism when a considerable artery is cut across, or punctured, and the blood does not find a ready outlet by the external wound, it flows internally, and may inject the cellular membrane of a whole limb, and so separate the vessels from their surrounding connexions, as to cause them afterwards to ulcerate upon the application of a ligature, and the patient to perish from secondary hemorrhage; or gangrene may ensue from the general pressure occasioned by the extravasation. If a *moderate* quantity of blood be effused, it seldom passes far beyond the boundaries of the wounded vessel, where it forms a coagulum which gives a temporary restraint to the hemorrhage; in the mean time, the external wound heals, and the loose cellular membrane around

the coagulum also closes up and forms a sac, which invests the clotted mass. A tumour is thus formed on the side of the wounded vessel, the cavity of which communicates with that of the artery, constantly receives small portions of fresh blood, and at last comes to resemble the most common variety of the true aneurism, differing from it only in this—that the sac is formed not by the dilated external coat of the artery, but by the loose cellular membrane exterior to that coat.



Treatment of Aneurism.

Spontaneous cures of aneurism, although reported by writers, must be considered extremely rare. Such an event may be brought about by two or three different causes—by the formation of a large and firm coagulum, which fills not only the entire sac, but, perhaps, a part of the artery above it—from the tumour, by change of position, pressing upon and obliterating the superior or inferior portion of the artery—by inflammation and sphacelation of the sac and whole tumour. The first is the most frequent, the second seldom met with, and the third, when it does occur, usually attended with distressing symptoms, and sometimes followed by fatal consequences. A fourth mode by which a spontaneous cure may be effected, has been noticed by some writers—the stoppage of the caliber of that part of the artery, immediately below the tumour, by the accidental separation of a fragment of coagulated mass lining the cavity of the sac. It appears to me, however, that this conclusion is gratuitous, or at least not altogether supported by well attested facts.

Much may be done towards mitigating the symptoms of aneurism, and arresting the progress of the disease—by frequent and repeated blood-letting, by rigid abstinence, by confinement to bed or to the horizontal position, by the internal use of digitalis, and the external application of various astringents and refrigerants. Such remedies cannot, however, be depended on in the generality of cases; although examples have been cited by Val-

salva, Morgagni, and other old writers, and more recently by Pelletan, of perfect cures having been effected under various circumstances by the foregoing means. On this account, the practice should always be pursued whenever the tumour is so large and so situated as to render the operation by the ligature impracticable; but success cannot be calculated upon, unless the depleting system be carried to the utmost extremity.

There are two modes, in the shape of an operation, practised for the cure of aneurism—*compression* and the *ligature*. Compression is now seldom resorted to—experience having proved its general inefficacy. The process has been found, moreover, even when successful, so extremely painful and tedious, that few patients can be induced to submit to it, or to persevere sufficiently long to accomplish a cure. That it operates, partly, upon the principle of the ligature, when it does succeed, there can be no doubt, by compressing the sides of the vessel, causing the effusion of lymph, and finally, obliteration of the channel, so as to force the blood to abandon the sac, and pass off by the collateral branches. When applied to the sac itself, such an effect, owing to the interposition of the coagulated mass, can rarely, if ever, be produced. Different machines for compressing aneurismal arteries or tumours, may be found in most systems of surgery.

The *ligature*, then, may be considered as the only mode of operation upon which any great reliance can be placed in the treatment of aneurism, and this, too, frequently fails. From the numerous and diversified experiments of Dr. Jones and others, it appears that a ligature, when applied to an artery with sufficient force, divides the internal and middle coats, leaving the external coat entire. The blood, arrested in its passage by the approximation of the sides of the vessel, soon coagulates and forms a plug extending as high as the first collateral branch. This serves as a temporary barrier, and takes off the force of the circulation from the ligature and the extremity of the artery. In the mean time, the divided edges of the artery pour out lymph, which is not only effused in the cavity of the vessel, but between its coats; the irritation, also, excited by the ligature, gives rise to an accumulation of lymph on the outer surface of the artery. At last, the external coat, continually irritated by the ligature, sloughs, or ulcerates, and the ligature is detached, leaving the mouth and

edges of the vessel filled and surrounded by a bed of lymph, into which vessels shoot, and by uniting the sides of the artery form a permanent closure. After a time, the coagulum is absorbed, and the channel of the artery as high as the first anastomosing branch, is obliterated and converted into a solid cord. Long before this process is completed, however, the blood, forsaking the main route, passes through the collateral vessels, which vessels gradually enlarge in proportion to the force of the column driven into them, until at last they equal or exceed in the aggregate the size of the original trunk, and the circulation becomes fully re-established.

But, instead of a cure being always accomplished in this happy manner, it sometimes happens that *secondary hemorrhage* results, and the patient either dies or is with difficulty saved. Such an event may be referred to several different causes—to the improper form, mode of application, and premature removal of the ligature—to a morbid condition of the aneurismal artery—to a deficiency of coagulum within the caliber of the vessel—to an unnecessary denudation of the coats of the artery, and perhaps to some other causes.

If a ligature, instead of being round and small, is flat and large, and twisted or irregular in shape, it is not well calculated to divide the internal coats, or it does not divide them throughout their circle. Upon the same principle, if a large portion of the surrounding cellular membrane, or a contiguous nerve, be included in a ligature, the coats are partially divided or not divided at all. Again—even if the ligature be of a proper form and well applied, if, through the officiousness of the surgeon, it is pulled away before the adhesive process is perfectly accomplished, and lastly, if from an ill-formed knot, the ligature be forced by the impetus of the circulation from the mouth of the artery, hemorrhage results. In most of these instances, the coats of the artery inflame from irritation, or the vasa vasorum being compressed or destroyed, the vessel is deprived of its nourishment, and ulcerates or sloughs, either at its mouth or above the ligature.—An artery is sometimes, in *false* aneurism, so separated from its surrounding connexions by extravasated blood, as to be completely insulated. Under such circumstances, it is soon, for want of support, reduced to a diseased state, and ulcerates if a ligature be applied to it. In cases of *true* aneurism, an artery is often ossified, or at least covered, at the place it is tied, with

calcareous depositions. Such an artery is extremely prone to ulceration, and there is nothing better calculated to excite it than the irritation of a ligature.—Although it has been stated that a coagulum is formed after the application of a ligature, it must be understood that under *particular* circumstances, this does not happen—as, for example, in cases where a vessel is tied *immediately below* a large anastomosing branch. There is no opportunity in such a case for a coagulum to form; consequently, the ligature and the new-formed tender lymph along the extremity of the artery, sustain the whole force of the circulation; hence, it sometimes happens, after the ligature is detached, that the lymph, unable to resist the current of blood, gives way and hemorrhage ensues. With respect to the “unnecessary denudation” of the vessel, it may be remarked, that the surgeon, from ignorance or want of dexterity, may mangle the parts adjoining the artery, and cut off all communication between them, so as to render the vessel unfit afterwards to bear the ligature.

It must not be supposed, however, that ulceration or sloughing, and secondary hemorrhage, will *necessarily* result from these causes; nor should it be inferred, that an artery cannot be permanently closed, unless the *internal* coats be divided by the ligature, nor that an ossified or denuded artery will *never* heal. Experience proves the contrary; but it also proves that the failure of the operation, in most cases, is owing to the circumstances pointed out.

Previous to the time of the celebrated Hunter, the practice of tying the vessel immediately above the tumour, and afterwards opening the sac and clearing it of the coagulated blood, was universal; but the operation so frequently failed, and the death of the patient so often followed, that this great pathologist was induced to investigate the subject in a particular manner. He found that the artery immediately adjoining the tumour was commonly in a diseased state, and therefore unable to bear the ligature; that the practice of opening the sac and removing its contents, excited a great deal of constitutional irritation, accompanied by sloughing of the tumour and of the contiguous parts; and that from these causes many patients lost their lives. Mr. Hunter at once conceived the ingenious idea of tying the artery at a distance from the sac, and of leaving the latter untouched; the result was highly satisfactory, and proved most decidedly

the value of his theory—that the artery should be tied in a *sound* part, and the sac and its contents removed by the absorbents. During Mr. Hunter's time, the operation was confined, almost exclusively, to popliteal aneurism; it has been extended by many surgeons of the present day to every other aneurismal tumour upon which an operation is admissible. An objection, however, has been made to the Hunterian operation, which seems not altogether destitute of foundation—the occasional return of the blood into the sac through those anastomosing vessels, which happen to communicate with the main trunk somewhere intermediate to the sac, and the place where the ligature is applied. But this so seldom occurs, that it can scarcely be considered an objection.

In performing the operation for aneurism, in general, it is only necessary for the surgeon to remember that he is to cut for a sound part of the artery, at a greater or less distance above the sac; that he is to penetrate cautiously with the knife, (not extending the incision an immoderate length, and tearing the surrounding parts by his fingers or by instruments,) until he observes the pulsation of the vessel, when he should endeavour to detach it only to such an extent from its connexions, as to enable him to pass a common aneurismal or crooked needle, armed with a small round ligature, beneath it. The ligature should then be firmly tied, and one end being cut off near the knot, the other should be left hanging from the wound, the edges of which must be closed by adhesive straps.

Many surgeons follow the practice of Mr. Abernethy, and apply two ligatures—afterwards dividing the artery between them. I am disposed to think, that few, if any, advantages are gained by this proceeding, and in certain cases that it will be attended with imminent peril.

Brasdor, and afterwards Desault, conceived that under particular circumstances—where the tumour, for instance, is so large or so situated that the artery cannot be tied *above* it—a ligature applied to the vessel *beyond* the tumour might effect a cure, by causing the blood to coagulate in the sac and upper part of the artery, as high as the first anastomosing branch. The experiment was tried by Deschamps and by Sir Astley Cooper—but without success, owing to one or more anastomosing vessels passing off between the sac and ligature, in such a way as

to keep up a constant stream of blood through the sac. At the Alms-House Infirmary, during the winter of 1827, in a case of femoral aneurism extending a considerable distance above Poupart's ligament, in a patient nearly 70 years of age, in presence of Professor Mussey, of New Hampshire, and several other medical gentlemen, I cut down upon the femoral artery immediately below the tumour, and compressed the vessel for some time between two fingers, with a view of ascertaining whether the pulsation in the tumour could be diminished, intending in that event to apply a ligature. So far, however, from any favourable change being produced by the compression, the pulsation continued without interruption, so as plainly to indicate that anastomosing vessels passed off between the ligature and sac. Under these circumstances, and particularly as the patient had long laboured under an obstinate cough, and some apparent disease of the great vessels within the chest, I resolved not to apply the ligature, but bring the edges of the wound together, and suffer it to close, which it did, though not without difficulty, in two or three weeks. This patient died during the autumn of 1829, and, upon examination, it was found that four vessels, each nearly as large as the femoral artery, passed off from the lower part of the sac. The iliac and femoral arteries, as well as the sac and smaller vessels, were covered with calcareous incrustations. If the artery had been tied, it would, in all probability, have taken on ulceration, and, at any rate, the operation could not have been productive of any benefit.

That the operation of Brasdor has, however, succeeded in a few instances, there is every reason to believe. Mr. Wardrop,* of London, who, within the last few years, has turned his attention particularly to the subject, and who deserves great credit for the persevering efforts he has made to establish the operation, has published the result of four or five cases, in some of which the termination is said to have been successful.

Mr. Wardrop has extended, likewise, the operation of Brasdor, to aneurism of the *arteria innominata*—by tying the subclavian or carotid arteries. He has reported the successful termination of a case of the kind, in which the subclavian was taken up by himself, and another by a Mr. Evans, who tied the carotid

* Wardrop on Aneurism. London, 1828.

artery for aneurism of the innominata, and succeeded perfectly. Within the last few years Dr. Mott, of New York, performed a similar operation, but the patient did not recover.

Other cases have been reported since, (making in all about sixteen or seventeen,) in which the operation has been performed, but without permanent benefit, except in a very few instances; from all which it may be inferred, that Brasdor's operation is, in every respect, a very dangerous and uncertain one—that it is liable to be followed by high inflammation, ulceration and sloughing, from the artery being tied (almost necessarily,) in a diseased part, and by secondary hemorrhage—that it can seldom succeed when collateral vessels pass off from the sac—that it ought never to be performed, unless other operations are impracticable, and the patient's life in immediate danger; and that, when performed, it should always be conjoined, if possible, with medical and other means.

Whatever mode may be selected for the operation of aneurism, there is one point upon which most surgeons entertain the same opinion—that little danger is to be apprehended of *gangrene*, from want of collateral branches, or free distribution of blood, except amongst arteries of the largest class.

SECTION II.

Aneurism of the Aorta.

THERE is no artery more subject to aneurism than the aorta; and, unfortunately, the disease, when thus situated, is seldom, if ever, cured. Owing to the rapidity with which the blood issues from the heart, and its forcible propulsion against the arch of the aorta, where it first meets with resistance, this portion of the vessel is particularly apt to suffer, and here the aneurism will be found, usually, to commence either in the form of a general dilatation of the coats, or, as is most frequent, by rupture of the internal and middle coat, with distention of the cellular; in which last case the tumour will be situated on one side of the artery—as explained in some of the preceding pages.

The *symptoms* of aneurism of the thoracic aorta are more or less difficulty of breathing, a sense of uneasiness and constriction about the chest, palpitation of the heart, severe pain, shooting from the sternum towards the arms, (compared by some patients to that produced by a rope drawn tightly around the chest,) a troublesome hacking cough, difficulty of deglutition, feeble and intermitting pulse. In the advanced stages of the disease, or in proportion as the tumour acquires bulk, all these symptoms are aggravated, and others often superadded, such as tremendous pulsation in the tumour and large vessels adjacent to it, or about the heart. Frequently it happens, that a part of the swelling rises above the sternum, in which case the disease is liable to be mistaken for aneurism of the innominata, carotid, or subclavian arteries. When the tumour attains a great magnitude, its pressure upon the sternum, ribs, or clavicles, causes their absorption; every barrier is then removed except the integuments; and the tumour, whose dimensions are sometimes enormous, projects be-

yond the chest. At last, the integuments, the sac, and its immediate coverings inflame and ulcerate, and masses of coagulated blood are discharged. Pressure for a time, perhaps, arrests their progress, but the ulcerated opening continues to enlarge, and finally the patient, oftentimes without a moment's warning, is destroyed by hemorrhage. In many instances, however, and long before the aneurism acquires any considerable bulk, it bursts into the chest, into the cells of the lungs, or into the pericardium, and instantaneously proves fatal. In some rare instances, communications have been established between the aneurismal sac and the pulmonary artery, or the œsophagus, or trachea, and, of course, with a fatal result.

There are several diseases about the chest, whose symptoms bear a similitude to those of aneurism of the aorta; such as enlargements of the bronchial glands, collections of serum or pus, which by pressure on the heart force it towards the right side of the chest, where it may be felt pulsating strongly, morbid thickening of the parietes of the heart, &c. On the other hand, aneurism of the thoracic aorta, from its pressure on the lungs, will sometimes give rise to symptoms resembling those of phthisis pulmonalis. For these reasons, the surgeon should be very cautious not to pronounce too hastily a prognosis.

The *abdominal* aorta is often the seat of aneurism. Generally, the tumour is situated immediately below the diaphragm, and owing to the little resistance it meets with from the loose and yielding textures surrounding it, soon acquires considerable bulk, and pulsates most awfully, and so distinctly and forcibly, as in some instances to elevate the bed-clothes, of which the patient and by-standers are very sensible. When the tumour becomes very large, there is not only dropsy of the belly and limbs, from pressure on the thoracic duct, but, destruction of the lumbar vertebræ, followed by paralysis of the legs, and eventually by the death of the patient, which for the most part is occasioned by a rupture of the sac, the blood of which is poured into the duodenum, stomach, or cavity of the belly.

Treatment of Aneurism of the Aorta.

Although Sir Astley Cooper has been adventurous enough to tie the abdominal aorta, in a case of aneurism of that vessel, I trust that there are in this country but few surgeons, if any, disposed to follow his example; for, certainly, there is reason to believe, that independently of the great irritation which must necessarily follow such an operation, gangrene would, in every instance, be the result,—from the want of an *adequate* supply of blood. This observation is made with a perfect knowledge of the fact, as stated by Scarpa, Hodgson, and others, “that if the aorta be tied in the dead subject immediately below its arch, and a thin injection be thrown into the upper portion of the vessel, it will pass into the arteries of the lower extremities.”

All that we can hope to accomplish, then, in most cases, is to arrest the progress of the disease, or save the patient's life for a time. This may undoubtedly be done by strict abstinence, repeated blood-letting, the internal use of digitalis, the external application of astringents and cold, and in the advanced stages, by supporting the tumour with leaden compresses, adhesive straps, &c. Some instances, indeed, of *perfect* cures having been accomplished by these means, are related, and upon most respectable authority. Few patients, however, can be brought to submit, for any length of time, to so rigid a system as the advocates of this practice have enjoined.

SECTION III.

Aneurism of the Carotid.

CAROTID aneurism, whether from a wound or from disease in the coats of the vessel, may be considered comparatively rare. It is met with chiefly in hard-working people, especially those accustomed to carry heavy burdens upon their heads and shoulders. The tumour may occupy either the common trunk, or else, the internal or external carotid. Generally, it is situated near the angle of the jaw, at the place where the artery divides. Like aneurism in most other situations, it may be known by its strong pulsatory motion, by its rapid enlargement, by the cough and difficulty of respiration, and of deglutition, occasioned by pressure of the tumour upon the larynx and œsophagus. It is sometimes, however, extremely difficult to distinguish between this disease and other tumours about the neck, and in the immediate vicinity of the artery. Common glandular or sarcomatous tumours, for example, if they happen to lie in contact with the carotid, have a pulsation communicated to them. In such cases, if the tumour can be elevated, or removed from the vessel by the fingers, the pulsation will cease, and the true nature of the disease become manifest. Again—if pressure be made upon an ordinary tumour, or upon the carotid running near it, the tumour is not diminished, whilst aneurism, treated in a similar manner, is sensibly decreased. Several cases are recorded of aneurisms of the aorta having ascended so high upon the neck, as to be mistaken for carotid aneurism.

Treatment of Carotid Aneurism.

The fact that the carotid of one or both sides, might be obliterated by disease, without curtailing the supply of blood destined for the brain, has been long known. Several instances, too, are mentioned by the older writers of wounds of the carotid terminating favourably, after the application of the ligature; but Sir Astley Cooper was the first, I believe, to tie this vessel in a case of aneurism; though the propriety of such a measure had been strenuously insisted upon by Mr. John Bell, as the following passage, (referring to the case of a woman who had been suffered to perish for want of an operation,) will evince. "Nothing could more tempt us to a daring experiment, than the desperate condition of such a patient, nor is there any thing in the relative situation of these parts to deter us; had this woman been under my care, or should ever such a case recur, I should never hesitate one moment, conscious that the most absolute bungler in surgery, might lay aside the muscle with a few strokes of his scalpel, open the common sheath of the carotid and its accompanying nerve, and separate the vein, nerve and artery, so as to tie the latter without let or hinderance."*

Since Sir Astley Cooper's operation, which was first performed in eighteen hundred and five, the experiment has been very frequently repeated, and has now become an established practice. To perform the operation to advantage, the patient should be placed in the recumbent position, with his head somewhat raised by a pillow, and slightly inclined towards the affected side. The surgeon then makes an incision two or three inches long on the inner edge of the mastoid muscle, commencing immediately below the tumour. An assistant pulls to one side the mastoid and sterno-hyoid muscles. This will bring into view the internal jugular vein, the omo-hyoideus muscle, and sometimes the decendens noni, all of which should be avoided. The next step of the operation is to expose and open

* Principles of Surgery, vol. 3, p. 254.

the sheath of the artery, which is easily done by pinching up the sheath with a pair of dissecting forceps, and making a horizontal cut into it. The sheath being opened, an aneurismal needle or flexible sliver probe, armed with a ligature, is passed around the artery; taking especial care, before tying the ligature, to exclude the par vagum. Having tied the artery fairly, and secured the ligature by two or three knots, its ends are left hanging from the wound, the lips of which should be closed by adhesive straps. A single ligature, in case of carotid aneurism, should always be employed; for if two ligatures be applied, and the artery divided between them (as advised by Abernethy) the patient would inevitably perish by hemorrhage, if, from any cause, the ligature should be detached.

SECTION IV

Axillary Aneurism.

ANEURISM of the axillary artery is sometimes met with. It may arise either from a morbid condition of the coats of the vessel, or from a wound. In whatever manner produced, the tumour enlarges with great rapidity, soon fills the arm-pit, and, not unfrequently, extends above the clavicle. The characters of the disease are so well marked, as to be seldom mistaken; yet instances are related of such tumours being opened by ignorant surgeons, under the impression that they were abscesses.

*Treatment of Axillary Aneurism.*

If the aneurism be small, and seated low in the axilla, which seldom happens, the surgeon may possibly find sufficient space between the sac and the clavicle, to enable him to include the axillary artery in a ligature; on the contrary, should the tumour be large, and occupy the commencement of the vessel, it will be necessary to tie the *subclavian* artery. The two operations differ materially from each other, on which account it will be necessary to describe them separately.

To tie the *axillary* artery, the surgeon should make an incision, (the patient being seated in a chair with his shoulders thrown a little backwards, and supported by an assistant,) two or three inches in length, commencing near the sternal extre-

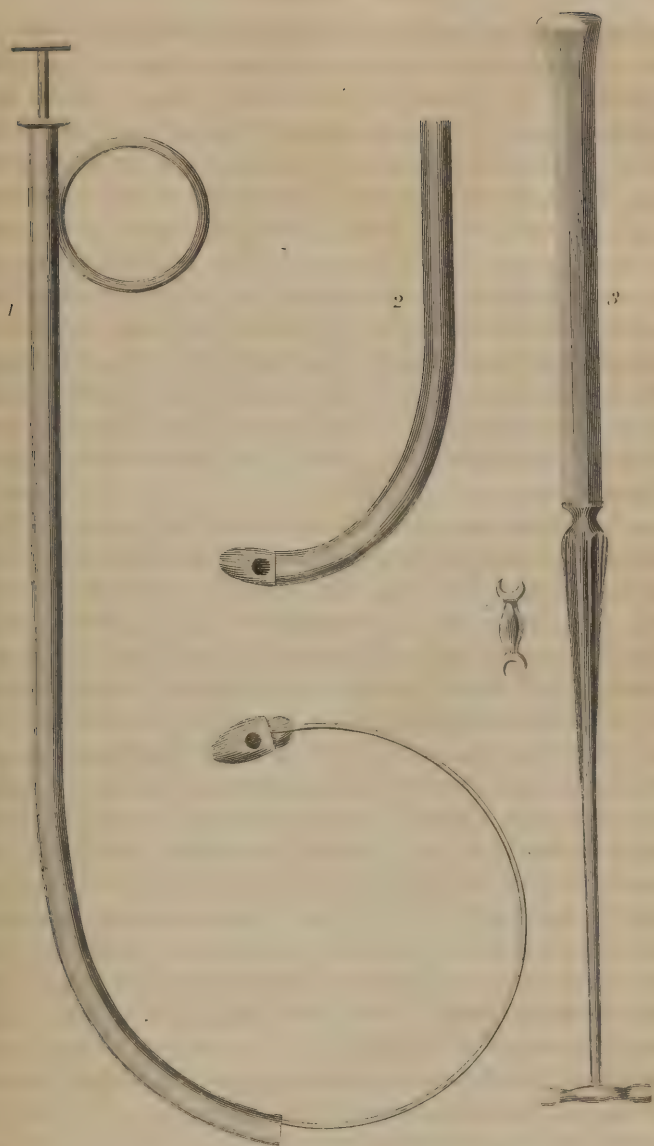
mity of the clavicle—running downwards in a semilunar direction and terminating near the edge of the deltoid muscle. Following the course of the external incision, the fibres of the pectoralis major should be next divided, until the pectoralis minor is exposed. Between the clavicle and the superior edge of this last muscle, the axillary artery will be found. Here the vessel is encompassed by the axillary vein, and by a plexus of nerves. The surgeon must, therefore, proceed very cautiously, lest he divide some of these parts with the knife, or include them in the ligature. The vessel being fairly exposed, and separated to such an extent as barely to permit the aneurismal needle, with its ligature, to pass beneath it, should be tied, when the pulsation in the tumour and at the wrist will immediately cease.

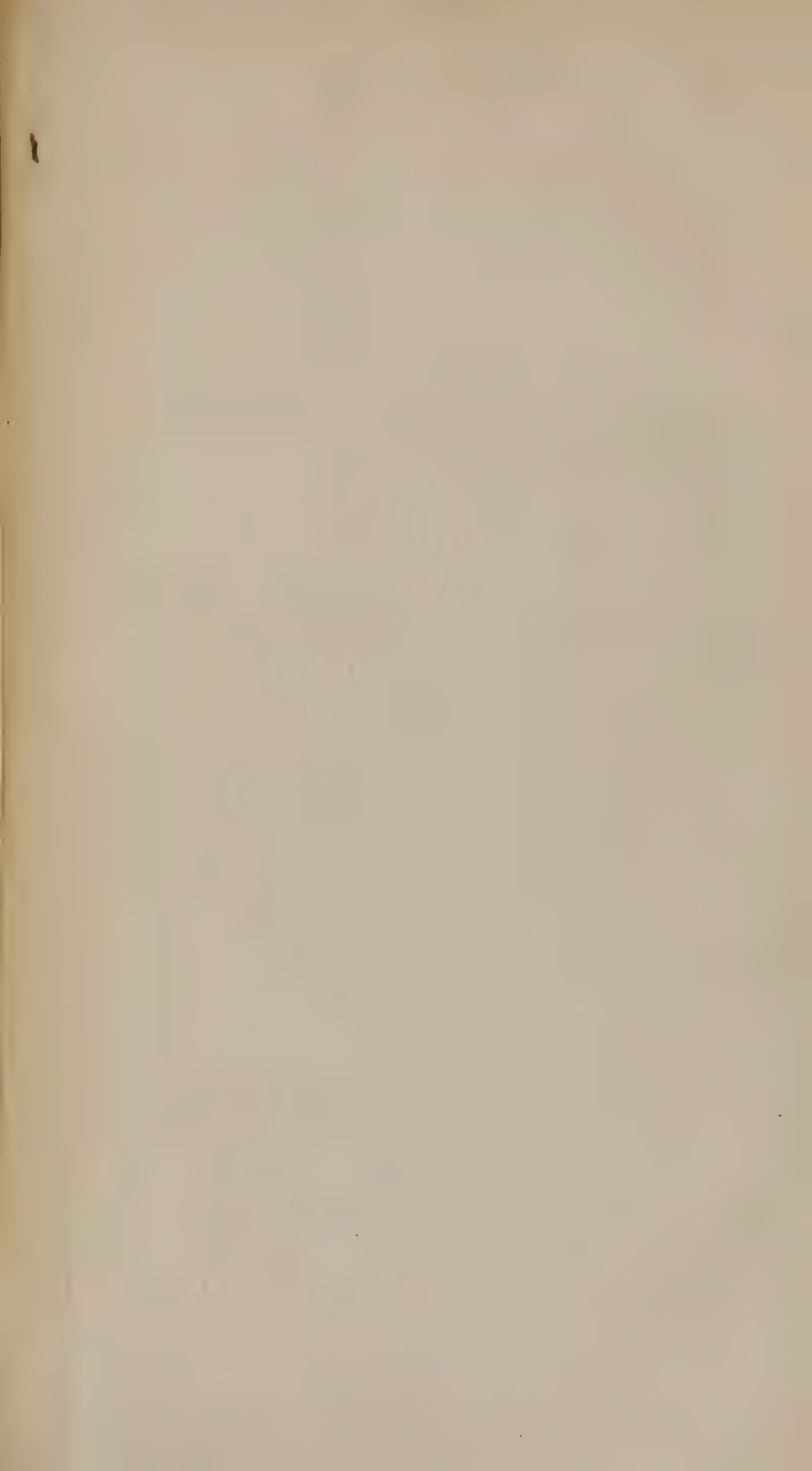
When it is necessary to take up the subclavian artery, (the operation commonly practised for axillary aneurism) the position of the patient will be found a matter of immense importance. He is seated on a low stool or bed, with his head thrown backwards, and inclined towards the sound side, and the posture steadily maintained by an assistant. Another assistant keeps the arm close to the chest, and at the same time pushes the shoulder downwards and forwards as low as possible. The surgeon makes an incision through the skin above the clavicle, commencing near the sternal extremity of that bone, and terminating at the anterior edge of the trapezius muscle. The fibres of the platysma myoides, and cervical fascia, are next carefully divided, until the external jugular vein is exposed. An assistant holds aside this vessel with a curved spatula or blunt hook, while the operator separates, with the *handle* of the knife, the loose cellular membrane, until he reaches the acromial edge of the anterior scalenus muscle. Near the origin of this muscle, from the first rib, the artery will be found. Owing, however, to the great depth of the vessel, it cannot be easily reached, (if the tumour is large) by the common aneurismal needle; on this account, particular instruments have been invented by Deschamps, Bellocque, Desault, Ramsden, Watt, and others. I prefer that of Bellocque, and the common artery forceps of Dr. Physick,* to most of them. Bellocque's instrument consists of a silver cannula, six inches long, straight at the upper extremity, and slightly curved at the lower,

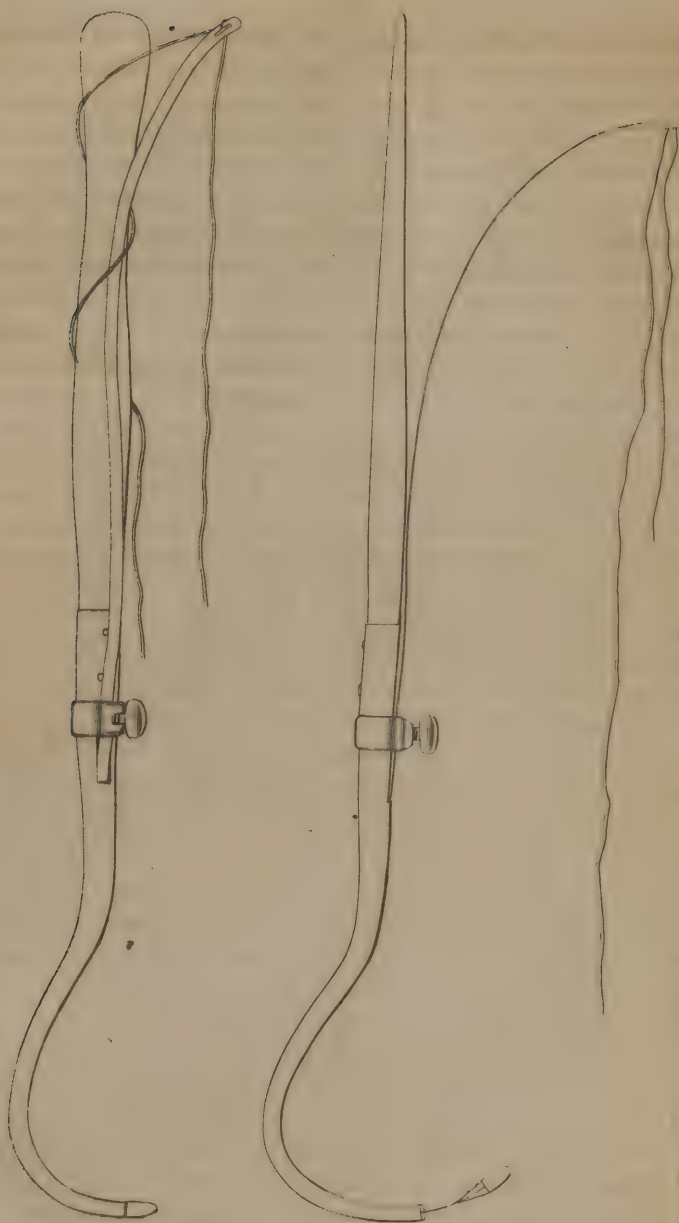
* See vol. i. p. 55.

containing within its cavity a watch-spring, which, by means of a silver stilet attached to it, may be pushed forward or retracted at pleasure. The lower extremity of the spring is covered by a small silver bulb, which not only serves to render the end of the cannula obtuse, but, from being perforated, to convey the ligature. A ring at the superior portion of the cannula, enables the surgeon to hold the instrument steadily. *Two different views of this instrument may be seen in Plate VIII. figs. 1 and 2.* Having laid bare the subclavian, the surgeon will experience no difficulty in passing beneath it this instrument, with the spring retracted, which being done, it only remains to push forward the stilet, when the spring ascends from the bottom of the wound, and a ligature being passed through the eye of the silver bulb, the whole instrument is withdrawn, carrying along with it the ligature and depositing it beneath the vessel.

An instrument, however, differing in principle from every other, which I have used upon several occasions, and which I published the following account of in 1828, is calculated, I think, to do away all the difficulties that surgeons have so long complained of. "Having experienced much greater difficulty than I expected in passing the ligature beneath the subclavian, I called soon after the operation, upon Mr. Schively, one of the most ingenious and eminent cutlers in the United States, and requested him to make for me an instrument of the shape and size of the common aneurismal needle, calculated to hold a steel stilet capable of being passed, without difficulty, beneath deep-seated vessels. His ingenuity soon removed the defects usually complained of, and produced an instrument, which I do not hesitate to say, in point of simplicity and usefulness, is as yet unrivalled. It consists of a silver cannula, fixed in a wooden handle, surrounded (near the part where the cannula joins the handle) with a silver collar, through which a steel stilet, made of a narrow watch-spring, the length of the instrument, passes, and immediately after enters an opening just below the collar, in order to traverse the whole cavity of the cannula and emerge at its point. This extremity of the stilet is covered with a flattened silver cap moderately blunt, whilst its other or *upper* extremity, passing upwards from the collar above mentioned, lays parallel with the handle, and has an *eye* near its end for holding a ligature. A small screw, for the purpose of fixing the stilet while the surgeon is in the act of







passing the instrument beneath the artery, works through the silver collar, and may be used or not as the surgeon pleases. It will be seen at once, that the great advantage which this instrument possesses over those in common use, is that the ligature being held by the upper instead of the lower end of the stilet, the surgeon can draw the stilet along with the ligature, at once, through the cannula and under the vessel—whereas, in other instruments, the ligature being passed through the *lower* end of the stilet, must, after having been carried beneath the artery, be in part retracted again before the surgeon can tie it.”* An additional stilet, if necessary, with a *sharp* point, may accompany the instrument. The use of the instrument, however, as well as its form and size, will be better understood by the drawing in *Plate IX. figs. 1 and 2.* It may sometimes be found, owing to the great depth of the wound, very difficult to close completely the knot of the ligature. In that case I would employ the ingenious contrivance of Dr. Alexander Hosack of New York, which, by holding the first knot firm, enables the surgeon to tie a second or third with the utmost facility. This instrument is so simple and so easily understood, as to render a description of it superfluous. *See Plate VIII. fig. 3.*

Although both the axillary and subclavian arteries have been repeatedly tied in cases of axillary aneurism, yet it is to be lamented that the operation has very seldom succeeded. This may, perhaps, be ascribed to the operation being generally delayed too long, or to the same disposition to disease in the vessel, which gave rise to the aneurism itself. The operation, however, has proved, satisfactorily, that there is no want of collateral branches, and consequently seldom danger of gangrene from want of a supply of blood. The honour of having first *successfully* tied the subclavian artery is due to the late Professor Post of New York.

The project of tying the *arteria innominata*, in certain cases of axillary and subclavian aneurism, has been suggested by different surgeons; and my friend Dr. Mott, of New York, was bold enough, a few years back, to try the experiment—but without success. A similar operation has since been performed by Græff of Berlin, and with a similar result. I have no disposition to condemn these

* See Gibson's Case of Axillary Aneurism, in *Philadelphia Journal of Medical Sciences* for 1828; and vol. 1st of this work, p. 337.

attempts, because every effort towards saving the life of a fellow creature, when he must necessarily perish, without relief, should be deemed praise-worthy; but I cannot help thinking that the chance of success must necessarily (owing to the great size of the innominata, its contiguity to the heart, and the probably diseased condition of its coats) be so very limited, in most cases, as not to justify the practice. Another objection, and a very strong one, that might be urged against tying the innominata, is this—that subclavian and axillary aneurisms have sometimes been cured *spontaneously*. A ligature upon the carotid or subclavian, I should conceive the proper plan in all cases of the kind.

SECTION V.

Brachial Aneurism.

It is remarked by Hodgson, that he has “never seen an aneurism in the arm which was not produced by accidental violence.”* The experience of other surgeons confirms the statement, and proves a diseased condition of the coats of this vessel to be a very rare occurrence. The most frequent cause of the aneurism is a wound of the artery at the bend of the arm from the common operation of blood-letting. The external wound having healed, the blood is gradually diffused in the cellular membrane around the artery, and beneath the fascia; a tumour is thus formed, which, in proportion as it augments, causes the fingers and fore-arm to contract, (owing to the unyielding nature of the fascia, or the firm aponeurotic expansion of the biceps) the limb to diminish, and the patient to experience very considerable numbness and pain.

*Treatment of Brachial Aneurism.*

Surgeons are unaccustomed, now, except under particular circumstances, to lay open the aneurismal sac at the bend of the arm, and evacuate the clotted blood; experience having proved that the Hunterian operation is as well calculated to succeed here, as in other parts of the body. The aim, therefore, of the

* Diseases of the Arteries and Veins, p. 389.

operator, in brachial aneurism, is to cut for the trunk of the artery at some distance above the sac.* The tourniquet being loosely applied, chiefly with a view to render the subcutaneous veins conspicuous, and to prevent the surgeon from wounding them, an incision should be made through the integuments, about two inches and a half in length, along the inner edge of the biceps muscle, and about the middle of the arm. The fascia being next divided, the cellular sheath, containing the artery, veins, and radial nerve, will be brought into view; and upon opening this, the artery may be readily found and tied; without risk, if the surgeon is at all careful, of including nerves or other contiguous parts. A common aneurismal or curved needle will be sufficient to convey the ligature: and this being tied, the wound is dressed in the ordinary way.

* A larger share of experience has taught me, that the Hunterian operation is not to be relied upon to the extent I have stated; for I have found that when the artery is simply tied in one place above the tumour, that the pulsation will be apt to continue or return in the sac, through the medium of collateral branches. Dr. Physick has made the same observation; and Dr. Hartshorne informs me that he was obliged, in one case, to cut down and tie the artery below the sac, before he could effect a cure. Upon the whole, then, I am inclined to believe that the safest, and least troublesome practice, will be to tie the vessel above and below the sac, in the generality of cases.

SECTION VI.

Inguinal Aneurism.

WHEN a true aneurism forms, at or near the bend of the groin, a small circumscribed pulsating tumour is perceived, which, from the femoral artery being closely surrounded by dense cellular membrane, and covered by the unyielding fascia of the thigh, increases very slowly, and sometimes so insensibly that neither the patient nor surgeon are aware of its nature, or, perhaps, mistake it for an enlarged inguinal gland, or a hernia. In time, however, these doubts are dispelled by the increase of the tumour, by the general swelling, numbness, coldness, and insensibility of the limb, and, finally, if the disease is permitted to run its course, by the inflammation, and, perhaps, sphacelation of the sac, when the patient will either perish from hemorrhage or from irritation, or else obtain, as has sometimes happened, a spontaneous cure.

Treatment of Inguinal Aneurism.

Although Guattani and Mr. John Bell, had amply demonstrated the existence of very large and numerous inosculation, calculated, as they believed, to afford a full supply of blood to the thigh, in case the femoral artery should be obliterated, or

tied, above the origin of the profunda, it remained for Mr. Abernethy to prove by an operation on the living subject, the correctness of their views. This distinguished surgeon, in a hopeless case of femoral aneurism, was induced, in seventeen hundred and ninety-six, to tie the *external iliac* artery, and though the patient did not recover, he lived long enough to evince the propriety of repeating the operation in subsequent cases. Mr. Abernethy's second attempt was alike unfortunate; but his third and fourth were crowned with complete success, and served to establish the operation, which has since been repeatedly executed by different surgeons, and often with the happiest effect. In America, the operation was performed, for the first time, by the late Dr. Dorsey, in eighteen hundred and eleven, and with a result that usually followed the efforts of that accomplished surgeon.

Mr. Abernethy's operation for inguinal aneurism, which I prefer to that of Sir Astley Cooper, or any other I am acquainted with, is executed in the following way. The patient being laid upon a table, an incision should be made in the course of the external iliac, commencing about an inch and a half from the anterior superior spinous process of the ilium, and extending within half an inch of Poupart's ligament. The tendons of the external oblique muscle being cut through to an extent corresponding to the wound in the integuments, a finger should be carried beneath the margins of the internal oblique, and transversalis, to prevent the peritoneum from being injured while the surgeon is dividing these last mentioned muscles. As soon as this stage of the dissection is completed, the finger can be readily passed behind the peritoneum as far as the inner edge of the psoas muscle, where the external iliac artery, and its corresponding vein will be found. The vein, running along the inner side of the artery, should be gently separated from that vessel by the finger nail, or handle of the knife; a ligature may then be passed around the artery, by means of the aneurismal needle, and tied; and the wound being dressed, the patient must be put to bed, and the muscles of the limb kept in a relaxed position.

Gluteal aneurism is occasionally met with; and it was formerly the practice, in such cases, to lay open the sac, and secure the artery where it emerges from the pelvis. The late Mr.

John Bell performed a terrific operation of the kind, upon a tumour of immense size, and succeeded, though with great difficulty, in curing his patient. His example was followed in a few other cases; but the high inflammation, suppuration, and caries of the innominatum and ischium that sometimes ensued, induced surgeons to seek for less formidable measures. To Dr. Stevens, of Santa Cruz, the profession is greatly indebted for a more simple and effectual operation—namely, the application of a ligature to the *internal* iliac artery. From experiments made upon the dead body, Dr. Stevens was induced to believe that the internal iliac might be taken up in the living subject, and a case of gluteal aneurism, nearly as large as a child's head, having presented itself to him in 1812, he determined to try the experiment. "An incision, above five inches in length, was made," says he, "on the left side, in the lower and lateral part of the abdomen, parallel with the epigastric artery, and nearly half an inch on the outer side of it. The skin, the superficial fascia, and the three thin abdominal muscles, were successively divided; the peritoneum was separated from its loose connexion with the iliacus internus and psoas magnus; it was then turned almost directly inwards, in a direction from the anterior superior spinous process of the ilium to the division of the common iliac artery. In the cavity which I had now made, I felt for the internal iliac, insinuated the point of my fore-finger behind it, and then pressed the artery between my finger and thumb. Dr. Lang now felt the aneurism behind; the pulsation had entirely ceased, and the tumour was disappearing. I examined the vessel in the pelvis; it was healthy, and free from its neighbouring connexions. I then passed a ligature behind the artery, and tied it about half an inch from its origin. The tumour disappeared almost immediately after the operation, and the wound healed kindly. About the end of the third week the ligature came away, and in six weeks the woman was perfectly well." Dr. Stevens informed me, during the winter of 1831, that he found no difficulty in avoiding the *ureter*, which retired along with the peritoneum when that membrane was raised from the tumour.

Mr. Atkinson, of York, in England, next tied the internal iliac artery for gluteal aneurism, in 1817, but the patient died

on the nineteenth day after the operation. A Russian surgeon is said to have been the third person who tied this vessel, and the fourth operation of the kind was performed by Dr. S. P. White, of Hudson, New York state, in 1827. With the exception of Mr. Atkinson's, these patients all recovered; and this fact is sufficient, consequently, to establish the operation.

The *common* iliac artery was *first* tied by myself so far back as the year 1812—in a case of gun-shot wound. The patient lived *thirteen* days after the operation, notwithstanding the unfavourable circumstances of the case, and died, finally, from peritoneal inflammation and secondary hemorrhage. He lived sufficiently long, however, to prove satisfactorily to me, that the largest artery in the body, (except the aorta,) might be tied without cutting off permanently the supply of blood to the lower extremity—for the circulation of the limb was re-established on the seventh day—and to enable me to lay down the *principle*, which I then did, that *aneurisms* of the *external* and *internal* iliac arteries should be treated by tying the *iliaca communis*. This I consider the more important, inasmuch as surgeons were accustomed at that time to view such aneurisms as necessarily fatal. It affords me great pleasure to add, that my friend Dr. Mott of New York, acting upon the principle I had established, has been able to demonstrate the practicability of my proposal, by tying *successfully* the *iliaca communis* in a case of aneurism of the internal iliac artery, an operation which in every point of view does him great credit, and the following account of which, cannot fail to be read with peculiar interest. “The tumour was of large size, protruding the belly considerably at the iliac region; the patient suffered most excruciating pain, which appeared to increase as the tumour enlarged. Dr. Mott's incision extended from the external abdominal ring, to one or two inches above the crest of the ilium, dividing the tendon of the external oblique, and cutting through part of the origins of the internal oblique and transversalis. He then cautiously raised the peritoneum with his fingers, and succeeded in detaching it entirely from the tumour and vessels, without doing it the slightest injury. The artery was then examined, and the aneurismal dilatation was found to cease at about half the distance between the bifurcation of the aorta and the origin of the internal iliac branch. The ligature was passed from the outside of the vessel, by the aid of

the instrument devised by Drs. Parrish and Hewson,* carefully avoiding the iliac vein. The protrusion of the intestines rendered this part of the operation the most difficult. After the ligature was passed around the vessel, the wound was held open in such a manner as to allow the medical gentlemen present to see, and satisfy themselves of the exact situation of the ligature, which was just below the bifurcation of the aorta into the primitive iliacs, and on the side of the sacro-vertebral promontory. The ligature was then drawn tight and secured; the pulsation of the tumour ceased; its size was much diminished, and the patient was relieved from the agonizing pain, previously unremitting. The wound was lightly dressed, and the patient put to bed; the limb of the side operated on was cold, as might be anticipated; it was wrapped in cotton, and covered up to preserve the temperature until the circulation should be restored. To the great surprise and satisfaction of the surgeon, in a little more than half an hour after the operation, the circulation and temperature were entirely restored, and all fear respecting the supply of blood to the limb effectually dissipated. No untoward circumstance occurred after the performance of the operation. The patient complains of no inconvenience, except a peculiar sensation of fulness or tension, in the limb, as if the small vessels had not yet become accustomed to their new office in sustaining the great mass of the circulation for the support of the member.”†

* An imitation of Dr. Physick's instrument for taking up deep-seated arteries.

† *Philad. Jour. of the Med. and Phys. Sci.* for May.

SECTION VII.

Popliteal Aneurism.

THE popliteal artery is peculiarly subject to aneurism; so much so, that many surgeons consider the disease nearly as frequent as that of aneurism of the aorta. It may arise either from a wound, or from a diseased condition of the coats of the vessel; but the latter is by far the most common. It is difficult to assign very satisfactory reasons for the extraordinary frequency of this complaint; for although there can be no doubt that the almost incessant motion of the knee joint, the great weight it is accustomed to bear, the shocks it is liable to, and the resistance which the blood must often encounter from the acute angle formed by the artery when the leg is bent upon the thigh, will contribute more or less to the rupture of the coats of the artery; yet the same causes should operate, to a certain extent, upon the arteries of the axilla and elbow; *true* aneurism, however, of the axillary artery, is rather uncommon, and that at the bend of the arm almost unknown.

However induced, popliteal aneurism may be known by the situation which the tumour occupies between the ham-strings, by its distinct pulsation in the early stages of the disease, by its gradual increase, by the great pain and numbness in the ham and calf of the leg, occasioned by pressure on the branches of the sciatic nerve, by the general swelling and œdema of the limb,—from the veins and lymphatics being obstructed,—by coldness of the whole limb, from diminished supply of arterial blood, by want of pulsation in the tumour, after it has attained a large size, and by the contraction and injury of the knee joint—which is almost sure to follow the disease when of long standing.

Treatment of Popliteal Aneurism.

So few patients recovered, after the old operation of opening the sac of the popliteal aneurism and tying the artery immediately above it, that many intelligent surgeons abandoned the practice altogether, and in place of it amputated the thigh. How much we owe to the illustrious Hunter for his discovery of the true mode of managing the disease, may easily be estimated when I state that any surgeon who should now venture to amputate, except under very particular circumstances, in any case of aneurism, must encounter the severest censure and disgrace.

The operation, upon the Hunterian principle, as now usually performed, is as follows. An incision is made, while the patient is in the recumbent position, along the inner margin of the sartorius muscle, commencing about two inches and a half below Poupart's ligament, and extending downwards between three and four inches, through the integuments of the thigh. Having reached the sartorius, its inner edge may be gently separated from the surrounding cellular membrane, and being held to one side by an assistant, the surgeon next proceeds to divide to the extent of an inch, the fascia lata of the thigh, beneath which he will find the femoral artery and vein and the saphena nerve enclosed in their sheath. The sheath being opened, and care taken to exclude the nerve and vein, the ligature is passed by the aneurismal needle, around the artery and tied. The wound is afterwards dressed in the usual way.

SECTION VIII.

Aneurism by Anastomosis.

THIS variety of aneurism was first particularly noticed by Mr. John Bell,* and denominated by him aneurism by anastomosis, on account of the tumour being formed of an assemblage of small arteries and veins, with an intermediate cellular structure. "The tumour," says he, "is a congeries of active vessels, and the cellular substance through which these vessels are expanded, resembles the cellular part of the penis, the gills of a turkey cock, or the substances of the placenta, spleen, or womb." Aneurism by anastomosis often arises from some slight injury; the tumour at first is scarcely perceptible; gradually, however, it enlarges, and acquires a thrilling, pulsatory, or jarring motion, which, together with its evident vascularity, forms its chief characteristic. In the early stages, the skin is seldom discoloured, but in the latter it has a mottled or purple hue, arising apparently from numerous small sacs of blood distributed throughout the tumour. These sacs, towards the surface, are apt to fret and take on ulceration: when this occurs, troublesome and very profuse hemorrhagies ensue. Frequently the disease seems closely allied to those vascular specks or growths, so common on the head and other parts of new-born children, known by the name of *nævi materni*.

Treatment of Aneurism by Anastomosis.

I have never known more than one instance of *spontaneous* cure of aneurism by anastomosis: this happened several years

* See Principles of Surgery, vol. i. p. 456

ago in the child of a distinguished lawyer of Maryland. The patient was under the care of an able and accomplished physician—Dr. William Bradley Tyler, of Fredericktown—who consulted me respecting the case. The tumour filled up the hollow behind the angle of the jaw, involved a part of the ear, was very large and vascular, and pulsated with such violence as to appear, when the child cried, ready to burst. I advised the speedy removal of it, by the knife, as the only mode of saving the child's life, and it was resolved, for this purpose, to bring it to Philadelphia. The journey, however, was delayed, in consequence of a fever with which the patient was attacked, and which continued for a considerable time. From that period the tumour diminished, and shortly afterwards disappeared—leaving in its place only a loose bag or fold of skin. The records of surgery do not furnish, I believe, a similar termination.

Two operations have been proposed for the cure of aneurism by anastomosis—*Compression* and *excision* of the tumour. The first seldom answers, but, on the contrary, generally aggravates the disease; the second is always hazardous, and never succeeds unless every vestige of the tumour be completely eradicated. Mr. John Bell laid it down as a rule never to be deviated from—"not to cut into the tumour, but cut it out." This, however, if it be a large aneurism, cannot always be done at once, or so readily as might be imagined. At all events, it is easier said than done. Very small tumours of this description, especially if seated over a bone, may, no doubt, be removed by one or two sweeps of the knife; but to point out what I conceive to be the true mode of managing this disease after it has attained an inordinate bulk, I relate the following case.

Elizabeth Loush, a married woman, twenty-five years of age, residing in the neighbourhood of Reading, came to Philadelphia in the month of April, 1823, anxious to obtain relief for a very large pulsating tumour, which nearly covered the right side of her head, and sometimes bled so profusely from numerous ulcerated spots on its surface, as frequently to endanger her life. This tumour had existed from infancy, but its increase was so gradual, and the pain attending it so inconsiderable, that it gave her little uneasiness. After her marriage, however, and especially during her second pregnancy, (in which she was advanced four months at the time I saw her,) the growth

of the swelling was so rapid, its pulsation so alarming, and the hemorrhagies from it so frequent and debilitating, that she was prepared to submit to any operation I might propose for her relief. I was aware at once of the nature of the disease, and saw plainly the necessity of acting promptly and decidedly. To have dissected off a tumour of such magnitude, and so extremely vascular, at a *single* operation, would have been little better than madness. I resolved to proceed in a very different manner, and having placed my patient in a private department of the Alms-House Infirmary, I commenced without delay a series of operations. My first object was to cut off temporarily the chief supply of blood to the tumour. With this view, I made several incisions, each about an inch long, through the scalp and at some distance from the margin of the tumour, and tied the chief branches of the occipital and temporal arteries, many of which were enlarged to the size of the common carotid. Having in this way encircled the diseased mass, I had the satisfaction to observe the pulsation diminish, and the tumour partially to shrink; the hemorrhage, also, from the surface had ceased. A slight erysipelas of the scalp followed the operation. This occasioned a week's delay; in the mean time, the blood was evidently finding its way again through the anastomosing vessels to the tumour. An incision was made, about two inches long, by a single stroke of the knife, through the integuments to the bone, commencing near the back part of the ear, and midway between the edge of the tumour and the line at which the arteries were taken up in the first operation. An incredible quantity of blood issued in a moment from every part of the wound; in a few moments, however, every vessel was secured. The cut was then repeated to the extent of three inches more, and the vessels in like manner secured. By this time the patient was so extremely faint, as to render it impossible to proceed further; indeed, many of the spectators supposed her to be dying. Without delay, therefore, she was conveyed to bed, and the wound dressed, by interposing lint between its edges to prevent their reunion. In ten or twelve days the patient had so far recovered her strength, as to enable her to submit to a further incision of the scalp, commencing at the place where the last operation had terminated. This operation was also continued as long as the patient could bear it, or as was deemed



prudent. Lint was then placed in the wound, and the patient put to bed, and carefully nourished for a fortnight, at which time the third and last operation was performed—by dividing the remaining portion of the integuments, and removing the tumour from the bone. This was accomplished with comparative facility, the tumour being by the preceding operations nearly drained of its blood, and almost insulated. Care was taken in separating the diseased mass not to remove the pericranium; the bones, therefore, notwithstanding a great portion of the parietal and occipital was exposed, did not exfoliate, but were covered in a few days by florid and healthy granulations, the edges of the wound gradually approximated, and were so far closed in four or five weeks, as to enable the patient to return to the country, where in a little time longer her health was perfectly re-established, and at the end of the usual period, she was delivered of a promising son. An idea may be formed of the magnitude and appearance of this tumour, by an examination of the drawing in *Plate X*.

Some surgeons may possibly feel inclined to imagine that a ligature upon the carotid would have saved both myself and patient a great deal of trouble, and have answered all the purposes of the apparently complicated operation I have described. I have the most perfect conviction, however, that such an expedient would have proved at least abortive, if not hazardous, and that, whatever benefit may have resulted from the practice in the cases detailed by Travers, Dalrymple and others, where the tumours were small, no prospect of advantage can be held out for such an operation, when the disease is far advanced and the swelling large. In corroboration of this opinion, I may state that I performed an operation for a disease, in many respects similar to that of Elizabeth Loush in February, 1830, upon Mr. David C. Ballard, of Albemarle county, Virginia, who had previously submitted to the operation of tying up the occipital artery—enlarged five or six times beyond its usual dimensions—and without the slightest diminution of the pulsation of the tumour. Not satisfied, however, with this experiment, I determined to repeat it before resorting to the excision of the aneurism; but the operation proved fruitless, and only served the purpose of lessening the pulsation for two or three days. Firm compression, too, of the carotid on each side, al-

though made with great accuracy and continued for some time, produced no alteration in the size of the swelling or in its pulsation. Influenced by these circumstances, I determined to remove the tumour, by a series of operations, and was rewarded for the trouble and difficulty I experienced with a perfect cure of the disease. During each operation, an immense number of large and small arteries were divided, anastomosing, apparently, with all the vessels of the scalp, convincing all who witnessed the operations, of the impossibility of curing such tumours by any other means than those I had recourse to. For the last twenty or thirty years Dr. Physick has, in several instances, successfully pursued a similar plan; indeed, the practice may be said to have originated with him.

SECTION IX.

Varicose Aneurism.

VARICOSE aneurism is that variety of the disease, in which a communication is established directly or indirectly between an artery and vein, in consequence of a simultaneous wound in both vessels. Dr. William Hunter was the first who gave any regular account of the disease, though cases of it had been previously recorded by Sennertus and others. The disease is comparatively rare, but is generally met with at the bend of the arm, in the usual place of venesection, by which operation it is commonly produced. Three or four instances are related of its having occurred in the ham and thigh, from gun-shot and other wounds. It may take place in any situation where a large artery and vein are in contact, or near each other, and happen to be punctured at the same moment. Under these circumstances it usually happens that there are two wounds in the vein and one in the artery; that the external wound in the vein heals, while the internal remains open and receives a stream of blood from the corresponding orifice of the artery; that the edges of these openings and the sides of the vein and artery to a certain extent become united by the adhesive inflammation, by which an unnatural route is established for the circulation in that portion of the body which happens to be the seat of the injury. Instead, however, of the artery and vein being always thus united, so as to afford a direct passage to the blood, it occasionally happens, that they are separated some distance from each other, so that when wounded, the blood is poured from the artery into the adjacent cellular membrane, out of which a sac is formed, and this sac being placed between the two vessels, the blood is first discharged into it, and afterwards into the vein. Mr. Hodgson is of opinion that these varieties of the disease are entitled to different names. The former he calls *anurismal varix*, the latter *varicose aneu-*

rism, without, as I conceive, sufficient reason; for the only difference* between them is, that in the one case the circulation between the vessels is *direct*, in the other *indirect*. The symptoms, moreover, are commonly the same. These symptoms are an unnatural distention, or varicose enlargement of the injured vein and of the veins in its vicinity, which is particularly conspicuous at the immediate seat of the disease, and communicates to the finger a peculiar, pulsatory, thrilling sensation, or vibratory motion, that may be compared to the forcible separation of the fibres of a quill, or, as remarked by Dr. Hunter, to the noise produced in the mouth by continuing the sound of the letter R in a whisper." Not only is there an enlargement of the vein, but of the artery also, and in some instances to a considerable distance above the seat of the wound. The limb beneath the tumour is frequently emaciated, from being defrauded of its due proportion of blood.

An exceedingly well marked case of varicose aneurism I met with in eighteen hundred and thirteen. The subject of it was upwards of sixty years of age, and had been wounded by a bayonet at the bend of the arm, which, no doubt, transfixed the artery and vein; for from that moment a tumour, possessing all the characters I have described, began to form and gradually increased until it attained the size of a large egg. The veins communicating with it were uncommonly large, varicose, and very tortuous. Enlargements, also, of the artery, at the bend and middle of the arm and above the clavicle, were very manifest; all of which possessed a strong, pulsatory, and, at the same time, oscillatory or tremulous motion. Although the patient had been, after his wound, and indeed up to the period I met with him, a hard-working creature, little or no inconvenience was experienced from this disease, and he applied to me on account of another affection unconnected with his aneurism. The case was in every respect so strongly marked, that I was very anxious to possess an exact resemblance of the original. With this view I took an impression of the arm in plaster, nearly as high as the shoulder, and from it a cast† in wax, from which the drawing in *Plate XI.* has been copied.

* The two diseases, however, may terminate in a very different manner, or require a different treatment, as will be explained presently.

† This preparation is still contained in my cabinet, and illustrates, most satisfactorily, the appearances presented by varicose aneurism.

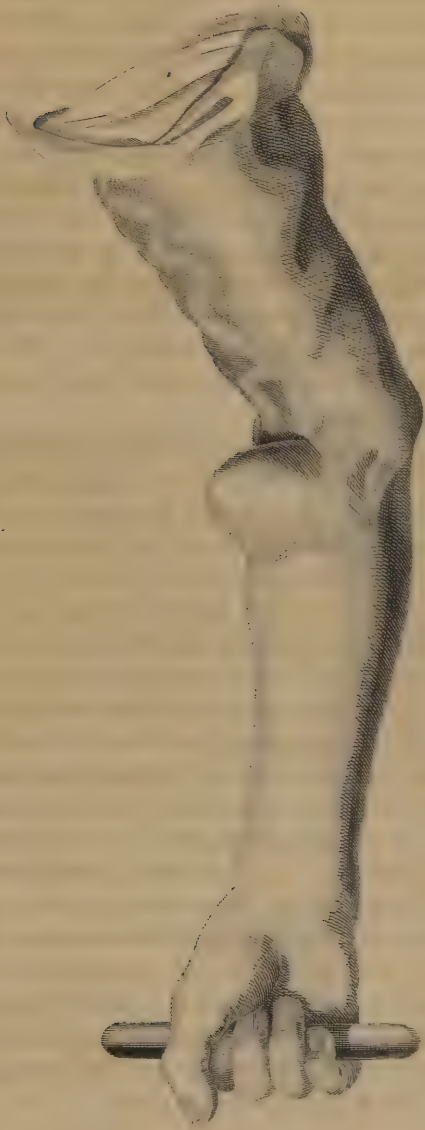


Fig. 1. Arm of a man.

Treatment of Varicose Aneurism.

The most common form of varicose aneurism—that in which the artery and vein communicate directly with each other—very seldom requires any other treatment than moderate compression. Indeed, even this is not always necessary, and may, sometimes, prove injurious, by obstructing the passage of the blood into the vein and forcing it into the cellular membrane, thereby causing the second variety of the disease. In most cases, it will be sufficient for the patient to abstain from violent or laborious exertions of the limb in which the aneurism is seated. But even this does not always cause the tumours in the vein and artery to enlarge, for, in the case I have detailed, the patient had been accustomed to laborious employments for twenty or thirty years without any material alteration in his disease. If an operation is performed for this disease, it should be done in the early stage of it.

When an aneurismal sac is formed out of the cellular membrane, between the artery and vein, it frequently attains so large a size, as by pressure to injure the surrounding parts, or by bursting or taking on ulceration, to endanger the patient's life. To guard against, or obviate such consequences, an operation may possibly become necessary. This was first performed by Mr. Park,* of Liverpool, and next by Dr. Physick.† In both instances, the brachial artery was tied above and below the sac, and the patients recovered. Of late years, the operation has been performed repeatedly, and generally with success.

* Medical Facts and Observations, vol. 4.

† Coxe's Philadelphia Medical Museum, vol. 1.

On Aneurism, consult *J. Bell's Principles of Surgery*, vol. 1.—*Abernethy's Surgical Works*, vol. 1, p. 272, edit. 1819—*Scarpa on Aneurism*, by Wishart, 1819—*C. Bell's Operative Surgery*, vol. 1, p. 70—*Pelletan Clinique Chirurgicale*, tom. 1 and 2—*Richerand's Nosographie Chirurgicale*, tom. 4, edit. 4—*Burns' Observations on some of the most important Diseases of the Heart, on Aneurism of the Thoracic Aorta, &c.* p. 203—*Burns' Observations on the Surgical Anatomy of the Head and Neck*, edit. 1824—*Hodgson's Treatise on the Diseases of Arteries and Veins, containing the Pathology and Treatment of Aneurism and Wounded Arteries* 8vo., 1815, decidedly the most valuable work extant.

CHAPTER XIII.

DISEASES OF THE VEINS.

PREVIOUS to the discovery of the circulation of the blood, the structure and functions of the venous system were very much studied; since that period, the attention of surgeons has been directed almost exclusively to the arteries, and the veins have been neglected. Like the arteries, however, they are subject to important changes, or to disease in their coats, which frequently give rise to serious, and even fatal consequences.

A common disease of the veins is inflammation. This may arise from wounds, as in venesection, or from the application of the ligature. In either case the lining membrane of the vessel is the chief seat of the disease, and along this membrane the inflammation, sometimes, travels until it reaches the heart—producing great irritation and symptoms resembling those of typhus fever. In other instances an effusion of coagulable lymph takes place, and the sides of the vessel being thus glued together, frequently in different places, the extent of the inflammation is limited, or pus, if it should form, prevented from passing through the circulation, and the patient's life, probably, thereby saved. This obliteration of a vein from the effusion of lymph, is sometimes produced slowly by pressure from an adjoining aneurismal sac, or some other species of tumour. In all such cases the circulation is carried on by the collateral veins, which anastomose so freely throughout the body with the main trunks, that little inconvenience is experienced from the obstruction, even although veins of the largest class be obliterated.

Inflammation of the veins sometimes terminates in ulceration, and gives rise to hemorrhage. This, however, is a rare occurrence; the formation of calcareous concretions in the venous coats is equally rare. Veins are occasionally ruptured from muscular exertion, from engorgement or over-distention of their coats by blood, produced by sudden immersion in a cold bath, or by other causes. But the most common venous affection, perhaps, is varicose enlargement, of which it will be proper to treat in a separate section.

SECTION I.

Varicose Veins.

THE deep-seated as well as the superficial veins, are frequently rendered varicose by undue muscular exertion, by interruption of the circulation from ligatures, by the pressure of tumours, by collections of hardened fæces in the intestines, by the enlargement of the gravid uterus, &c. If from any of these causes the disease is once induced, it continues gradually to increase and to extend from one vein to another, until numerous ramifications are affected. The veins of the upper extremities rarely become varicose, but those of the leg and thigh, especially the saphenæ and their branches, are very prone to the disease. In the commencement, numerous small circumscribed swellings may be observed. After a time, the venous trunks and branches appear enlarged throughout their whole extent, and run in a serpentine or tortuous direction. Sometimes they are knotted or doubled upon each other, and these gyrations are particularly conspicuous in the neighbourhood of the valves. In proportion as the veins enlarge, the support afforded by the valves to the column of blood is diminished, until it is entirely lost. Not only are the veins expanded greatly beyond their natural size, but their

coats also, in many instances, are very much thickened. This, together with the coagulated blood which not unfrequently fills their cavities, renders them solid and incompressible. Under particular circumstances, these coagula are absorbed, and the diseased veins are converted into cords. In by far the greater number of cases, however, the vessels remain pervious, and the fluid blood still circulating through them sluggishly, keeps up incessant irritation, and gives rise to inflammation in the surrounding cellular membrane, that often terminates in extensive and very painful ulcerations.* Profuse hemorrhage, from sudden rupture or ulceration of a varicose vein, followed by extreme debility and even death, has repeatedly happened.

Treatment of Varicose Veins.

In addition to compression with the roller and laced stocking, which, in slight cases, are well calculated to effect a cure, the older surgeons frequently extirpated large portions of the trunks or branches of varicose veins, sometimes with success, but oftener with an unfavourable issue. On this account the operation has long been abandoned, and that of simply including in a ligature the largest varicose trunk substituted in its stead. This mode of practice, although familiar to Celsus and other ancient writers, was introduced to the notice of the profession many years ago by Sir Everard Home, and has since been executed repeatedly by different surgeons, generally without any serious consequences, but sometimes with a fatal result. Many surgeons of the present day, therefore, never resort to the operation, especially as there is no certainty of a radical cure. Sir Astley Cooper, a surgeon of great experience, pointedly condemns the practice, and states that he has known it to prove fatal in eight instances. "Another overwhelming objection to

* See an account of the varicose ulcer, in vol. i. p. 154.

the operation," says he, "is, that when it does not prove fatal, its ultimate effects are useless. If I were asked which of the following operations I would rather have performed upon myself, viz. the saphena major vein or the femoral artery tied, I certainly should choose the latter."* In opposition to Sir Astley's statement, that the operation is never permanently useful, I may remark, that I have practised Sir Everard Home's plan of taking up the vena saphena above the knee, for the last eighteen or nineteen years; in numerous instances, without an unpleasant symptom, and generally with great relief to the patient and a speedy cure of the accompanying ulcer. It is an operation, however, that I have never undertaken lightly or upon every common occasion, being fully aware of the danger of inflammation extending along the inner surface of an injured vein to the heart. Of late years, Mr. Brodie, in order to avoid the occasional ill effects of the ligature, has proposed, as a substitute, the simple division of the vein by the knife;† but this operation, also, it is stated, has sometimes been followed by fatal consequences. Petit was in the habit of opening varicose veins with a lancet, and withdrawing the coagulated blood; after which, in many instances, he found that the vessels became obliterated, and the patient experienced no further inconvenience from the disease. Even drawing off, occasionally, small quantities of fluid blood by puncture, produces great relief. This mode of treatment, indeed, conjoined with the use of the roller, astringent washes, and an elevated position of the limb, will often effect a cure, and should always be tried before an operation is resorted to.

* The Lectures of Sir Astley Cooper, by Tyrrel, vol. i. p. 205.

† "For this operation," says Mr. Brodie, "I have generally employed a narrow sharp-pointed bistoury slightly curved, with its cutting edge on the convex side. Having ascertained the precise situation of the vein, or cluster of veins, from which the distress of the patient appears principally to arise, I introduce the point of the bistoury through the skin on one side of the varix, and pass it on between the skin and the vein, with one of the flat surfaces turned forwards and the other backwards, until it reaches the opposite side. I then turn the cutting edge of the bistoury backwards, and in withdrawing the instrument the division of the varix is effected. The patient experiences pain, which is occasionally severe, but subsides in the course of a short time. There is always hemorrhage, which would be often profuse if neglected, but which is readily stopped by a moderate pressure, made by means of a compress and bandage carefully applied."

SECTION II.

Cirsocele.

THE veins of the spermatic cord, and those of the scrotum, often become varicose. To the former the term *cirsocele*, has been applied—to the latter *varicocele*. The two diseases sometimes exist simultaneously. *Cirsocele* is chiefly met with amongst young, vigorous, unmarried men, those especially who have led very chaste and exemplary lives. In several instances I have known it connected with despondency or hypochondriasis. When examined, the whole of the cord appears to consist of a congeries or bundle of knotted and tortuous veins, which feel like a bunch of worms wrapped around and twisted upon each other. Generally, the disease first shows itself at the bottom of the testicle or scrotum, and thence gradually travels up the cord, producing more or less weight, uneasiness, or pain. When the patient is laid in the recumbent position, the tumour subsides, and the diseased veins feel soft and flaccid. The moment, however, he stands erect, especially if, at the same time, the upper part of the cord be compressed with the finger, the tumour reappears. This will serve to distinguish *cirsocele* from *hernia*, *hydrocele*, and other complaints.

Treatment of Cirsocele.

It is seldom that the testicle, or cord, sustains any injury from varicose enlargement of its veins. Sometimes, however,

it happens that the testicle, from long continuance of the disease, or from neglect, wastes away. To guard against this, and to relieve the unpleasant weight and uneasiness, of which most patients complain, there is nothing so effectual as a *bag* truss, so contrived as to suspend the testes and give them a firm and equable support. Conjoined with this, cold astringent washes, applied by means of linen rags to the affected parts, will be found highly serviceable. Robust and plethoric patients will also derive benefit from general and local blood-letting, from purging, low diet, &c. Extirpation of the diseased veins has been practised by some modern surgeons, in cases of cirrocele attended with severe pain and extraordinary enlargement of the cord and testicle. I have seldom met with cases requiring an operation of the kind.

On Diseases of the Veins, consult—*Hunter's Observations on the Inflammation of the Internal Coats of Veins*, in *Transactions for the Improvement of Medical and Chirurgical Knowledge*, vol. 1, p. 18—*Hodgson on the Diseases of Arteries and Veins*, p. 511—*Observations on Varix and Venous Inflammation, &c.*, by Richard Carmichael, in *Transactions of the Association of Fellows and Licentiates of the King's and Queen's College of Physicians in Ireland*, vol. 2, p. 345—*Home's Practical Observations on the Treatment of Ulcers of the Legs, to which are added some Observations on Varicose Veins, &c.* p. 274—*On Wounds and Ligatures of Veins*, by B. Travers, in *Surgical Essays by A. Cooper, &c.* part 1, p. 227—*Brodie's Observations on the Treatment of Varicose Veins of the Leg*, in *Medico-Chirurgical Transactions*, vol. 7, p. 195—*Oldknow's Case, in which the Operation of Tying the Vena Saphena, for the Cure of an old Ulcer of the Leg, terminated fatally*, in *Edinburgh Medical and Surgical Journal*, vol. 5, p. 175—*C. Bell's Operative Surgery*, vol. 1, p. 89 and 94—*Delpech's Precis Elementaire des Maladies Reputées Chirurgicales*, tom. 3, p. 251, *Article Varices*.

CHAPTER XIV.

INJURIES OF THE HEAD.

IN a pathological, as well as practical point of view, there are no diseases more deserving of the surgeon's attention, than those usually comprehended under the name of injuries of the head. These embrace several affections very distinct from each other in character, and requiring the most opposite modes of treatment. On this account, it will be proper to consider them in separate sections. It must not be supposed, however, that these diseases are always so well marked and insulated in their symptoms, and altogether so independent of each other, as never to exist simultaneously. This is so far from being the case, that we often find them blended or intermixed in a manner so extraordinary, as to puzzle or confound the most intelligent practitioner. Indeed, as has been well remarked by the experienced Hennen, "the young surgeon, who, for the first time, witnesses a series of injuries of this description, will at every step have something to unlearn; he will find symptoms so complicated, contradictory, and insufficient to give any rational clew to their causes; diagnostics, of the truth of which he had read himself into a conviction, so totally unsupported by the results of practice; and the sympathies he was led to look for as infallible accompaniments of certain states of disease, so often wanting altogether, that he will probably be inclined to relinquish the hope of ever arriving at a correct theory, or at least he will enter the clinical ward with the pride of science considerably subdued."

SECTION I.

Fracture of the Skull.

FRACTURES of the skull differ widely from each other in appearance and extent; hence their division by writers into several varieties, such as fissure, counter-fissure, depressed fracture, double depressed or camerated fracture, stellated fracture, punctured fracture, &c. These distinctions are of some importance, since the mode of treatment must in many instances depend upon the particular variety of fracture that may happen to exist. By the term fissure, is understood a simple crack or division of one or more bones of the skull; by counter-fissure, a separation produced at a point opposite to that upon which the force was applied. A depressed fracture is that in which the bones are forced beneath their natural level. The fracture is said to be camerated when "the centre is depressed in a direct line, and the sides decline towards that centre, like the form which the two hands make when laid together edgeways."^{*} A stellated fracture takes its name from the resemblance it bears to a star. Punctured fracture is the result of a pointed instrument driven through the bone. These varieties of fracture, are owing in part to the shape of the instrument by which they are produced, to the force with which it is impelled, and to the inequality of thickness and strength of the different bones composing the skull. Were it not for this inequality, counter-fissure would very frequently take place; for the skull being formed upon the principle of a hollow sphere, any force applied to it must extend its influence throughout the circle, and produce fracture at a point

^{*} See J. Bell's Principles of Surgery, vol. 2, part 2, p. 795.

opposite to that upon which the force was exerted. But this is prevented by the circumstance of some of the bones being thinner and weaker than others. If, for example, a man in falling backwards receives a violent blow upon the occiput, this bone being unusually thick and strong, does not give way, but the percussion is propagated towards the temples where the bones are weak, and here the fracture occurs. The same thing may arise from a blow upon the top of the head. In like manner, a force applied to the frontal bone, will often, instead of fracturing that bone, fracture the orbital plate. My preceptor, Sir Charles Bell, has satisfactorily illustrated these and several other interesting points relating to fractures of the skull in a most ingenious paper, contained in the first volume of his "Surgical Observations." In the paper referred to, Sir Charles not unaptly compares the skull to the roof of a house, in which the sphenoid bone serves as the *tie beam* to prevent the *rafters*, or parietal bones, from giving way. Again; the broad and expanded surface of the petrous part of the temporal bone is supposed to bear a resemblance to the *groining* of an arch in masonry, and, as such, to afford a foundation for the parietal bones to rest upon, while the mastoid, zygomatic, and petrous processes are likened to arches built under a wall to increase the security of the foundation.

Treatment of Fracture of the Skull.

Simple fissures or fractures of the cranium, unaccompanied by injuries of the brain or its membranes, seldom demand particular treatment. Indeed, there is reason to believe that such accidents often escape the notice of the surgeon, and are cured without his assistance. But even when the fracture is known to exist, the patient's safety may be endangered by officiousness in tracing it, or attempting its elevation. The rule, in all cases of the kind, should be to refrain from an operation so long as the contents of the skull remain unaffected, and of this the sur-

geon is to judge by the *symptoms*. It will always be proper, however, to remove sharp points or ragged edges of bone, by the cutting forceps, trephine or saw, to prevent them from irritating the dura mater, brain, or the soft parts exterior to the skull. In certain cases, also, the bone becomes carious some weeks after the fracture, and, if suffered to remain, may destroy the patient, by exciting inflammation upon the surface of the brain. The treatment necessary for fractures, conjoined with injury of the brain, will be pointed out under the head of *compression* of the brain.

SECTION II.

Concussion of the Brain.

IT often happens, that a man receives a smart blow upon the head, which does not fracture the skull, or materially injure the brain, but disorders the intellectual functions, and produces vertigo, sickness of stomach, trembling of the limbs, dimness of vision, &c. This may be considered a case of slight concussion. In more severe injuries of the kind, the symptoms are different. The accident is immediately succeeded by insensibility, coldness of the skin, relaxation of the extremities, feebleness and irregularity of pulse, difficulty of breathing, and dilatation of the pupil. The breathing, however, though weak and labouring, is commonly free from stertor. After a time the sensibility is partially restored, so that the patient may be roused from the apparent sleep or lethargy in which he is usually found, and made to answer questions, especially those relating to the seat of his injury. Gradually the pulse rises, and the natural breathing is restored, the pupil contracts and the body recovers its warmth. There is now danger of inflammation of the brain, since the pulse, in proportion as the immediate symptoms wear away, continues to augment in volume and strength, and the blood is determined forcibly to the head. Independently of this, in most cases of severe concussion, there is reason to believe that blood is poured out upon the brain or its membranes, in greater or less quantity, and afterwards becomes a source of irritation.

Treatment of Concussion of the Brain.

If called immediately after an accident, and symptoms of concussion are found to exist, the surgeon should be very careful not to adopt the practice, but too common among the ignorant and vulgar, of bleeding the patient instantaneously. But he must wait until the pulse rises, or until reaction is established, and this usually takes place in an hour or two; he will *then* bleed to diminish vascular action, and to prevent inflammation of the brain, which, in severe cases of concussion is extremely apt to ensue. If blood-letting, however, is pernicious in the first stage of concussion, the administration of stimulants will, generally, prove equally so; for although the patient may seem to be benefited for the time by a mouthful of wine or brandy, yet the effect of such practice will be, in the end, to hurry on the cerebral excitement. A few tea-spoonsful of cool water, immediately after the injury, will often be found singularly useful in reviving the patient, and cannot interfere with the after treatment. With regard to the continuance of blood-letting, much will depend upon the extent of the injury, and the age and constitution of the patient. Many instances are recorded of death from profuse evacuations of blood, designed to obviate inflammation of the brain. A medium must, therefore, be observed. In addition to blood-letting, low diet and purgatives should be resorted to. Applications to the head, which ought, previously, to be shaved, will also be found highly serviceable, such as cloths dipped in cold water, &c.; and after full benefit has been derived from these, blisters may be used with decided advantage: keeping the head in an elevated position, also, during the whole treatment, will greatly contribute towards the prevention and removal of inflammatory action.

SECTION III.

Compression of the Brain.

COMPRESSION of the brain may arise from three different causes—from a depressed fracture, from effused or extravasated blood, and from suppuration within the brain, or its membranes. It seldom happens, however, that a mere depression of the bone, unattended by other injury, will give rise to severe symptoms, or to such as characterize a compression of the brain. Indeed, the records of surgery furnish numerous examples of perfect recoveries after the most extensive depressions, from which the patients sustained very little inconvenience, and for the relief of which no operations were performed. On the other hand, cases are now and then met with, where, from depression of both tables of the skull, or from extensive fracture of the inner table, the most urgent symptoms have followed, but have been speedily relieved upon elevating the bones to their natural level.

Compression arising from extravasation of blood is very common, and may accompany fracture of the bone, or be independent of it. Sometimes the blood is poured out between the dura mater and the skull, in which case the membrane is actually shaken from the bone, and the blood issues from numerous small vessels. Sometimes the middle artery of the dura mater is torn by the rough edge of the fractured bone, or by the force which produced the fracture, and then the hemorrhage is very sudden and profuse. At other times, the vessels of the brain are torn, and the blood is spread over its surface, forced into its substance, or poured into the ventricles. In most cases of extravasation, there is commonly an interval between the injury and the appearance of the symptoms of compression, and this,

when it does occur, may be considered as a sufficient characteristic of its nature; for immediately after the vessels are torn, there is no compression, but as the blood accumulates and extends itself widely, the symptoms denoting that condition, are gradually developed and finally confirmed.

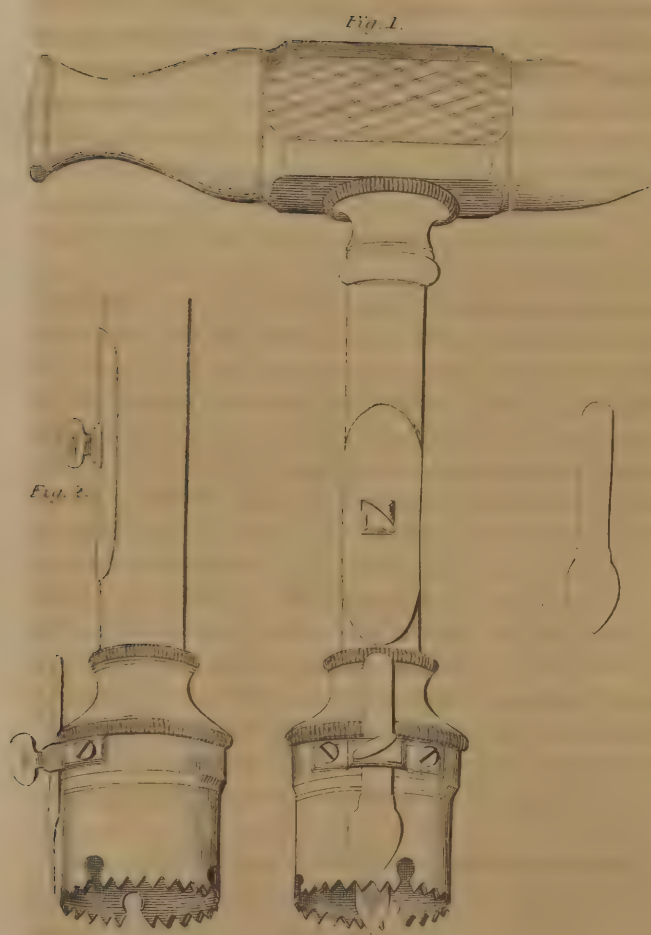
Matter, like the coagulum formed by extravasated blood, may give rise to compression; it is always, however, the result of inflammation, and, on this account, does not immediately follow an injury of the skull. Often it proceeds from the irritation produced by fragments of the shattered internal table, or from sharp or ragged spicula wounding the dura mater or brain. A depressed fracture, too, although it may not have produced, at first, symptoms of compression, will sometimes eventually cause suppuration on the surface of the dura mater. Even when the skull has not been fractured, but severely bruised, suppuration may follow with caries of the bone. Extravasated blood, also, may give rise to suppuration between the bone and dura mater or within the brain.

If from either of the foregoing causes compression should arise, it will be denoted by the following symptoms. The pulse will be found slow and regular, the pupils of the eyes greatly dilated and insensible to the strongest light, the breathing stertorous, slow and difficult, the limbs loose or yielding and sometimes paralytic, the insensibility complete, so much so that the patient cannot be roused by the most powerful stimuli. There is no sickness or vomiting. These symptoms will distinguish it from *concussion*, in which the pupils are either contracted or moderately dilated, the pulse weak and tremulous, the breathing without stertor, the insensibility partial, the affection of the stomach almost universal. It must be confessed, however, that we seldom meet, in these two states of disease, with the symptoms so insulated and distinct, as to enable us accurately to separate them; that, on the contrary, they are commonly combined, and so intermixed as often to create great confusion and doubt in the mind of the surgeon.

Treatment of Compression of the Brain.

When called to a patient labouring under all the symptoms of compressed brain, the surgeon can scarcely do wrong in drawing blood from the arm, and in repeating the operation as often as the pulse may seem to require it. In addition to this treatment, purgatives should be administered; and by pursuing this plan, he will often have the satisfaction to find that the symptoms abate, or are so entirely removed as to render an operation unnecessary; should he be disappointed, however, in this expectation, and an operation be afterwards demanded, the patient, from the previous depletion, will have a better chance of recovery. If, notwithstanding this treatment, the comatose symptoms continue, and there is reason to believe that the brain is oppressed by a coagulum, the trephine must be resorted to, whether the skull be fractured or not, and the coagulum removed. The same observation will apply to fracture with depression, always recollecting, however, that the *symptoms* call for the operation, and not the mere fracture; and that the skull, if the brain be uninjured, will often unite like any other fractured bone, even although the depression be left. On the other hand, it should be stated, that a depressed fracture, which at first did not interfere with the functions of the brain, will sometimes give rise to inflammation of the dura mater or brain, and subsequently to compression from the formation of matter; and that these consequences might have been prevented, perhaps, by a timely operation. But a great deal of judgment will be required to enable the surgeon to anticipate such consequences.

The *instruments* that may be required for an operation on the skull, are two or three trephines, the largest about an inch in diameter, the second three-quarters, and the third half an inch; all of them provided with sharp teeth widely set, and with *centre pins*; *Hey's saw*, a *lenticular*, *raspatory*, *trepan forceps*, two *elevators*, a *brush* for cleaning the trephine and saw, a *tooth-pick* or *probe*, *tenacula*, *sponges*, *crooked needles*, *ligatures*, a *scalpal*, &c.



The object the surgeon has in view in applying the trephine, is either to make an opening for the removal of coagulated blood, or for the introduction of the elevator beneath a depressed bone. In the former case a large trephine should be employed, in the latter a small one. Very frequently, however, it happens, that there is a sufficient space between the edges of the fragments of bone to insinuate the elevator, and with it restore the depressed portion to its natural level. Under such circumstances, the trephine need not always be employed. It is commonly recommended to plant the crown of the trephine partly upon the sound, and partly upon the depressed bone. Whenever the latter is sufficiently firm to bear the pressure of the instrument, I prefer resting it entirely upon it, in order to save the sound bone.

If there is a wound of the scalp along with the fracture, it may be enlarged, if necessary, or so changed in shape, as to enable the surgeon to get at the bone, and effect his purpose in the easiest way possible. If the integuments remain entire, I would recommend an incision, in the shape of the letter D,—the rounded portion of the letter to be raised from the bone. The flap of the integuments being turned back, the *centre pin* of the trephine, without the preliminary measure formerly practised, of scraping away the pericranium,* is fixed upon the bone, and serves the purpose of guiding the saw, which, being worked steadily backwards and forwards for a few minutes, forms a track or gutter for itself, in which it will afterwards run without the assistance of the pin. The pin being withdrawn, or made to retire within the axle of the trephine, the operator continues to divide the bone (occasionally removing the saw and brushing away the sawings, or dust, to prevent them from clogging the

* Having seen much mischief result from the common practice of rasping the pericranium, and from the teeth of the saw when applied in the way above directed, I have used, for some time past, a trephine with a small moveable lancet attached to its outer surface, the extremity of which can be made to project about the sixteenth part of an inch beyond the teeth of the instrument. The object of this is to cut the pericranium smoothly, instead of *tearing* it. As soon as this is accomplished, the operator may retract the lancet and proceed to saw the bone. The advantages gained by this simple proceeding must appear too obvious to require illustration; and yet I am not aware that either the principle upon which the operation is founded, or the instrument itself, have ever before been suggested or applied. (See Plate XII. figs. 1 and 2.)

teeth) until he has reason to believe that he is nearly through. He should then examine carefully and very repeatedly with the probe or tooth-pick, lest he cut into the dura mater or brain, before he is aware. Frequently it occurs, that one part of the bone is divided, whilst another remains entire. The surgeon in this case should discontinue the saw, and attempt the removal of the circular piece of bone, by breaking up its attachment with the forceps. Any irregularity or projecting edge of bone that may remain may be smoothed off by the *lenticular*. If blood be extravasated between the dura mater and skull, and the perforation has been made in the proper place, the coagulum will be presented as soon as the circle of bone is removed, and evacuated through the whole by the pulsation of the brain. If the blood be effused between the brain and dura mater, this membrane will sometimes be forced into the opening, and the dark blood will appear beneath it. The surgeon should then cautiously open the membrane, and evacuate the blood; though the operation does not commonly succeed when this is necessary. Still it is the only chance the patient has. In many instances, the moment the brain is relieved from the pressure of a depressed bone, or from the load of extravasated blood, the symptoms of compression instantaneously disappear, and the patient recovers his reason. In other cases the comatose state continues, and no benefit is derived from the operation.

If any large arteries are divided during the operation, they may be taken up by the tenaculum or needle. In a very extensive fracture of the skull, which I attended many years ago with Dr. Gustavus Warfield, an eminent practitioner of Maryland, I had occasion to tie up the middle artery of the dura mater: this was easily accomplished by the needle. Sometimes this artery runs in a groove in the bone: in that case, it may be compressed by a plug of soft wood. After the common operation of the trephine, the edges of the wound should be drawn together by adhesive straps, and secured by a pledget and light dressing.

For extensive extravasations, one or more openings with the trephine may become necessary. As it cannot always be determined readily whether there is extravasation or not, Mr. Abernethy has suggested the ingenious expedient of cutting down upon the bone, and scraping the pericranium before per-

forating the skull. This operation is founded upon the fact of the free interchange of vessels between the dura mater, bone, and pericranium, or rather upon the circumstance of the latter membrane being in a great measure dependent for its supply of blood upon the dura mater. Hence it was inferred, that if by a shock communicated to the skull the dura mater was torn up from the inner surface of the skull, the vessels passing through the bone to the pericranium must also be torn, and consequently that that membrane, if scraped, would not bleed, and *vice versa*. Mr. Abernethy has found this to hold true in practice, but his statements have not been confirmed *in toto* by other surgeons.

With the exception of the occipital bone, the trephine may be applied with equal effect, and comparatively with little danger to any part of the skull. When the frontal sinus is fractured, and it is necessary to trephine its inner table, two trephines should be employed—a large one for the outer portion of bone, and a smaller one for the inner portion. This mode of performing the operation was first pointed out by Sir Charles Bell. It is founded upon the unequal form of the sinus, in consequence of which a single trephine could not be made to work perpendicularly against its inner table. If a patient recovers after the application of the trephine, the external wound gradually heals up, and the opening in the bone is covered by a membrane, formed partly from the pericranium, and partly from the dura mater, which serves afterwards to protect the brain, but the bone is seldom, if ever, regenerated. If the patient dies after the operation, it is commonly from inflammation of the brain, or from suppuration within its substance. This will show the propriety of endeavouring to combat the inflammatory action, both before and after the operation. The trephine, when employed to evacuate matter from the brain, is seldom found to succeed. The trephine is sometimes employed for the relief of epilepsy. By Sir A. Cooper and Dr. Dudley, of Kentucky, several successful cases of the kind have been reported. When performed with this view, however, the operation has often failed—as was the case in a patient, upon whom I operated last winter, in the Alms-House Infirmary.

SECTION IV.

Inflammation of the Brain.

IF, from any of the causes pointed out in the preceding sections, inflammation of the brain should arise, it will be characterized by the following symptoms. The face becomes flushed, the eyes are red and impatient of light, the pupils are contracted, the skin hot, the pulse hard and quick, and the tongue dry. The pain in the head is intensely severe, the scalp is puffy and œdematous, retains the impression of the finger, has a peculiar glossy aspect, and the wound, if there be one, discharges a sanious matter. Soon after the appearance of these symptoms, the patient is seized with rigors or shiverings, which occur at irregular intervals, and are always indicative of great danger. During the early stages of the inflammation, the patient often continues sensible for days together, and answers questions very distinctly: when the disease is further advanced, however, he becomes irrational, moans or sighs heavily, tosses from one side of the bed to the other, mutters constantly, withdraws his hand from the surgeon, and seems unconscious of all that is passing around him. These symptoms are sometimes followed or accompanied by hemiplegia, and violent convulsions. If the patient survive until the suppurative stage is established, the matter will be found either between the dura mater and bone, between the pia mater and brain, in the substance of the brain itself, or in the longitudinal sinus.

Treatment of Inflammation of the Brain.

To counteract inflammation of the brain, or its membranes, the most active antiphlogistic measures must be pursued. Blood-letting is more to be relied on than any other remedy; but the surgeon should not be satisfied with merely drawing blood from the arm; he should take it freely from the scalp by leeches, or open the temporal artery, or the jugular vein. Purgatives, also, will be found essentially necessary, and after full effect has been produced by these and by blood-letting, the scalp may be covered with a large blister, which should be repeated as often as the symptoms require it. If, in spite of these remedies, the inflammation terminate in suppuration, and give rise to the symptoms of compressed brain, the trephine should be resorted to, though it must be confessed that the patient's chance of recovery is very limited, when such a measure seems to be called for. In some instances, months or years elapse before inflammation or suppuration of the brain takes place from injuries of the head. A carious bone, in such cases, will commonly be found to be the cause of the mischief, but, unfortunately, the removal of it by the trephine, will seldom prevent the patient's death.

SECTION V.

Fungus. Cerebri, or Encephalocele.

AFTER extensive fractures, and the removal of large pieces of the skull, or after the operation of the trephine, a tumour, having all the appearances of a vascular organized growth, sometimes sprouts from the brain, fills up the openings in the bone, projects beyond the scalp, and often acquires considerable magnitude. Commonly this morbid enlargement is first seen making its way through a laceration in the dura mater; but in other instances the dura mater ulcerates, from being forced repeatedly by the pulsations of the brain against the sharp edges of the bone, and the tumour appears immediately beneath, and afterwards increases with wonderful rapidity. Mr. Abernethy is inclined to believe that “this disease frequently consists of a tumour formed by coagulated blood, and that an organized fungus could hardly be produced in so short a time as that in which these tumours are usually formed.” Sir Charles Bell, on the contrary, maintains that the tumour is vascular, and formed of the substance of the brain itself; that it bleeds when torn or cut, which would not be the case if formed of a mere coagulum; that it is affected like spongy granulation by caustic, and collapses after death: all which, in my opinion, furnish decided evidence of its vascular nature. Indeed, Sir Charles’ views have been amply confirmed by the observations and dissections of subsequent writers. In particular, Mr. Stanley having had occasion to cut off a tumour of this description, found, upon dissection, “the exterior of the tumour to consist merely of a layer of coagulated blood, and the rest of the mass of brain, possessing a natural appearance, the distinction between the cortical and me-

dullary matter being readily seen with the convolutions and pia mater dipping down between them.”

Tumours, very different in structure from the foregoing, sometimes sprout from the external surface of the dura mater. They are apt to follow blows and other injuries of the head, in which the bone has been bruised, but not fractured. The patient, in such cases, usually complains of deep-seated severe headach, which may continue for weeks or months together. At last, a swelling is observed beneath the scalp, communicating a pulsatory motion to the finger, and rapidly enlarging, without the integuments taking on ulceration—though this sometimes happens in the advanced stages of the disease. If the integuments are divided, and the tumour examined, it will be found to consist of a vascular growth from the surface of the dura mater; a further examination will also show that the bone has been absorbed by the pressure of the tumour.

Treatment of Fungus Cerebri.

The termination of this disease is almost always unfavourable, especially when it is followed by symptoms of compression of the brain. Spontaneous cures sometimes, though rarely, take place—from the fungus being strangulated by the rapid increase of the surrounding granulations, or by pressure from the edges of the bone. From what I have seen of the disease, I am disposed to believe that light dressings, conjoined with occasional moderate pressure upon the tumour, will prove of more service than any other remedies. Caustics and excision have been highly extolled by some writers, and as pointedly condemned by others. “In the treatment of this disease,” says Sir A. Cooper, “you are to apply to the fungus a piece of lint, wetted with liquor calcis; and over this a strap of adhesive plaster: when you examine the parts, on the following day, you will find the fungus considerably diminished; you are then to

use a thicker piece of lint, and the strapping as before. Pursuing this plan, you at length bring the fungus to a level with the scalp; but this is not sufficiently low for your purpose; therefore, you must proceed until you have succeeded in getting it on a level with the bone; in which position it must be cautiously preserved, when at last the scalp heals over it, and your object is accomplished."

When a fungus protrudes from the external surface of the *dura mater*, and increases to such an extent as immediately to endanger the patient's life, its removal by the knife should be attempted. The operation, however, seldom succeeds.

Consult—Pott's *Chirurgical Works*, by Earle, vol. 1—Abernethy's *Surgical Works*, vol. 2—Desault's *Surgical Works*, by Smith, vol. 1—John Bell's *Principles of Surgery*, vol. 2, part 2—Hennen's *Principles of Military Surgery*, p. 277—Thomson's *Report of Observations made in the Military Hospitals in Belgium*, p. 49—C. Bell's *Operative Surgery*, vol. 1, p. 403—C. Bell's *Surgical Observations*, p. 461—Dorsey's *Surgery*, vol. 1, p. 291—Richerand's *Nosographie Chirurgicale*, tom. 2, p. 230—Lassus' *Pathologie Chirurgicale*, tom. 2, p. 252—Calisen's *Systema Chirurgiæ Hodiernæ*, tom. 1, p. 728, et sequent.—Stanley's *Cases of Hernia Cerebri, with Observations in Medico-Chirurgical Transactions*, vol. 8, part 1, p. 12—Sir Astley Cooper's *Lectures on the Principles and Practice of Surgery, with Additional Notes and Cases*, by Frederick Tyrrel, Esq., vol. 1, p. 252.

CHAPTER XV.

LOCAL DISEASES OF THE NERVES.

THE diseases to which the nervous tissue is subject, have received, with few exceptions, but little attention from surgical or medical writers. This has been owing, no doubt, in great measure, to the complicated structure of the nerves, their minute division, and intricate and endless distribution, the study of which alone would be sufficient to embrace no inconsiderable portion of time. There is great reason to hope, however, that the splendid discoveries of Sir Charles Bell, discoveries which have not only immortalized their author, but have shed a halo of glory around his country, have so unravelled the mysteries of the nervous system, as to open a rich mine for the observations and experiments of future inquirers, and that, at no distant day, the diseases of the nerves will be as susceptible of demonstration as those of the arteries and some other textures. Under the heads of neuritis, neuralgia, neuroma, and tetanus, I shall endeavour to include the chief surgical diseases of the nerves.

SECTION I.

Neuritis.

INFLAMMATION of the neurilema, or of the substance of a nerve, whether acute or chronic, and to designate which writers have employed the term neuritis, appears to be by no means unfrequent. Cases of the kind, strongly marked, and minutely detailed, have been furnished by Sir Everard Home, Martinet, Weinhold, Brandreth, Swan, Descot, Langstaff, Lobstein and others. The symptoms are deep-seated pain, sometimes constant, sometimes periodical, swelling and redness of the part affected, spreading in the course of the nerve or its branches, and followed by induration of the surrounding parts, and, eventually, by thickening of the nerve, from deposition of coagulable lymph in the interstices of its fibres. In some instances, the pain is intensely severe, accompanied by spasms of the muscles, and inordinate constitutional disturbance, hysteria, &c. Paralysis, or loss of sense of feeling in the affected part, is a frequent attendant, and in chronic cases of neuritis, is associated with extraordinary coldness and insensibility of the skin.

The *causes* of the disease are either constitutional or local. Incised, contused, lacerated, and gun-shot wounds, pressure upon nerves by ligatures, or by tumours, and various other injuries, may be considered as the most common of the local agents. *Ulceration* of the nervous tissue, as appears from the observations of Swan, Craigie, and others, sometimes follows an inflamed nerve. Swan, in particular, has related cases of ulcers of the leg in which the nerves were found, upon dissection, in an *ulcerated* state in some parts, thickened in others, or else surrounded or complicated with fungus.

Treatment of Neuritis.

In acute neuritis, constitutional, as well as local remedies in the shape of depletion, are chiefly to be relied on. Low diet, general blood-letting, leeches, purgatives, blisters, position and absolute rest, are essential in most aggravated cases of the disease. Sometimes it resists the combined operation of them all. In such cases, the preparations of opium and colchicum may be tried. Stramonium and hyoscyamus, in chronic cases, may be also resorted to. When there is reason to believe that the disease has been the result of local irritation, and is kept up by the pressure of a tumour, or by consolidation of the parts in immediate contact with the inflamed nerve, from ligatures or the cicatrices of wounds, a division of the parts by the knife, or amputation of the limb may become necessary. Langstaff has related the case of a female, whose fore-arm was amputated on account of an injury which had been followed by violent symptoms. The operation was productive of no benefit. Some months afterwards, a second amputation was performed above the elbow, the nerves were drawn out to the extent of half an inch, by the tenaculum, and cut off. From that moment, the patient was relieved of pain, and never had the slightest return of the severe symptoms she had so long suffered from.

“When very painful ulcers exist,” says Swan, “ointment made with powdered opium, or lotions made by mixing powdered opium with water, or lime water, should be applied on lint to the sore, and then a folded cloth moistened with water, or laudanum and water, over the surrounding skin, and attention should be paid to the digestive organs.” The same surgeon has recommended, in case of ulcerated nerves, the division of them, taking care to make the separation as far as possible from the ulcer, in order to prevent the divided extremities of the nerve from afterwards taking on ulceration.

SECTION II.

Neuralgia.

THIS, as the term implies, is a painful affection of one or more nerves, exceedingly common, which may occupy any organ or texture of the body; though it attacks the face oftener than any other part. By most writers it has been described under the title of *tic douloureux*. Whether seated in the head, face, cheek, spine, abdomen, or extremities, the symptoms are nearly the same. These are, a peculiar thrilling, darting, vibratory pain, commencing at a single point, and shooting along the course of one or more nerves, their filaments or branches; the pain is paroxysmal and periodical, and along with it there is generally muscular twitching. The degree of suffering varies in different patients, according to the parts attacked and the duration of the complaint. Some patients suffer immensely, and are so agonized as to be driven almost to desperation. But, generally, the pain, although extremely severe and frequent, is not intolerable, and is the more readily borne, as the paroxysms are succeeded by remissions, although there is seldom perfect immunity from suffering. For weeks, or months, the disease may endure, and at last wear away, and the patient console himself with the hope that it has been conquered. With all the regularity of an intermittent, however, it comes back, and sometimes renews the attack with more than usual ferocity. In other instances, the periodical visitation is not manifested, and for months and even years, the patient may be entirely free from the disease. The local symptoms enumerated, are in some cases preceded by general indisposition, such as chilliness, creeping sensations, gastric, uterine, and arthritic derangements. In other cases, the part is assaulted, without previous notice, and with a suddenness

and impetuosity, that surprises and alarms the patient. Marks of inflammatory action are seldom visible in the part affected, nor is the circulation so far disturbed, in the generality of cases, as to amount to fever, even when the pain is at the height of paroxysmal intensity. Every age and sex are amenable to neuralgic invasion; but middle-aged females, of various temperaments, and whose systems have been impaired by dyspeptic agencies, are most exposed to its assaults: on the other hand, very vigorous and athletic young men, and even children, sometimes become a prey to its ravages. Beside the parts already mentioned as most frequently implicated in neuralgia, we find the uterus, testicles, urinary bladder, kidneys, liver, spleen, rectum, stomach, heart, lungs, and brain, under the occasional influence of its operation.

The *causes* of neuralgia, are local and constitutional. Among the former may be enumerated, mechanical lesions of every description, such as incised, lacerated, punctured, penetrating, contused, gun-shot, and poisoned wounds. Pressure, of various kinds, whether acting directly on individual nervous trunks, or branches, through the medium of cicatrices, spicula of bone, ligatures, corsets, bandages, or indirectly, will often give rise to the disease. Abscesses, ulcers, caries, particularly when seated in, or near, the roots of the teeth, or about the face, or scalp, are equally powerful in inducing neuralgic aggression. The most prominent of the *constitutional* causes are, pallid exhalations, dyspeptic depravities, uterine irregularities, arthritic diatheses, hemorrhages, exposure to cold, mental emotions, masturbation, excessive venereal excitement and indulgence, immoderate use of tobacco, &c.

With rheumatism, and other complaints, neuralgia is often confounded. But rheumatic pain is pulsatile, dull, has no distinct remission, and is widely spread, while that attendant upon neuralgia is penetrating, vibratory, paroxysmal, and often periodical, and unaccompanied by inflammation. *Tic douloureux* of the face may be distinguished from toothach, by the pain attendant on the latter being deeply seated and continued, and by the swelling of the face and gums which accompanies toothach, and often ends in suppuration, and is unattended by that excruciating torture peculiar to neuralgic diseases.

Treatment of Neuralgia.

The local, and constitutional, causes of neuralgia being very numerous, and diversified, it is natural to infer that the curative indications, and modes of treatment, should hold a proportionate correspondence. We find, accordingly, that countless remedial contributions have been furnished towards the removal of the complaint, and that as soon as one specific has acquired a reputation and lost it, its place has been filled by another. "Sic unda supervenit undam."

The remedies, then, for neuralgia, must be looked upon, in most cases, as palliative merely. Under this head, may be enumerated general and local blood-letting, blisters, stimulating plasters, caustics, opiate and saturnine lotions, fomentations, poultices, acupuncture, compression by the roller or tourniquet, opiate and mercurial frictions, electricity, Galvanism, magnetism, the internal use of opium, belladonna, stramonium, hyoscyamus, quinine, sulphuric ether, arsenical solution, valerian, peroxide of zinc, sub-carbonate of iron, emetics, colchicum, subnitrate of bismuth, warm-baths. Of all these, most benefit appears to have been derived from quinine, sub-carbonate of iron, and emetics.

So far back as the time of Vesalius, the celebrated anatomist and surgeon, the division of the nerve, in tic douloureux of the *scalp*, was practised successfully. In the case of Prince Charles, (son of Philip the Second King of Spain,) who suffered immensely from a neuralgic affection of the scalp, succeeding a wound, Vesalius, by dividing that integument to the bone, effected a perfect cure in a very short time. Pouteau, one of the best of the older French surgeons, details two very interesting cases of the same kind; and, by pursuing a similar practice, was equally successful. From the result of these operations, there is reason to believe the modern practice of dividing the branches of the fifth pair of nerves in tic douloureux of the face originated—a practice now seldom resorted to, experience having proved its general inefficacy. It is not easy to imagine, indeed, how such a measure should prove permanently

useful, if the view taken by Sir Charles Bell, that “*tic douloureux* has its source in visceral irritation, communicated through the sympathetic nerve,” be correct. Why, it may be asked, then, has the operation ever succeeded? *Ultimately*, I believe, it very seldom has; for, out of numerous cases reported, immediately after the operation, as successful, a very small proportion only have received permanent benefit—owing, perhaps, to the difficulty of selecting the precise nerve, or of cutting off its communication with adjoining branches; but, above all, of preventing its *reunion*, even when portions of it have been cut out.

SECTION III.

Neuroma.

By the term neuroma, is to be understood an enlargement or tumour of a nerve. There are three or four varieties of the disease—one which is solid, or sarcomatous, situated as an interstitial deposit between the fibrils of the nerve, and which, by involving a number of these fibrils, may attain considerable magnitude—another, in form of a tubercle, about the size of a pea, and which occupies, there is reason to believe, one or more of the subcutaneous nerves—a third, which is seated upon the extremity of a divided nerve, in shape of a button-like excrescence, and is produced by the application of a ligature—a fourth, which seems to consist of gelatinous matter enclosed in a cyst, and appears to be a secretion from the substance of the nerve.

The first variety of neuroma was particularly noticed by Sir Everard Home, who, in 1796, detailed two cases of it, the first of which occupied the outside of the biceps muscle of the right arm, just below the middle, was the size of a pullet's egg, extremely painful when handled, and, when exposed by the knife, was found connected above and below to a strong white cord, which turned out to be the musculo-cutaneous nerve. In the second case, the tumour occupied one of the large nerves which form the axillary plexus; and, when dissected out, was found of a yellowish white colour, three inches and a half long, two inches thick, and of an oval form. Sir Charles Bell, in 1809, published a very interesting case of tumour of the tibial nerve, produced by a fall over the side of a ship, the ham of the patient being caught by a projecting bolt. For a long time the patient suffered extremely, not so much from the tumour as from pain in the foot, and finally died, worn out by long con-

tinued suffering and hectic. In 1812, I was consulted by a woman in the service of John Barney, Esqr., of Baltimore, on account of a tumour the size and shape of a goose-egg, seated on the inner edge of the biceps muscle, near the middle of the right arm, very firm and solid to the touch, moveable, but not particularly painful. Upon cutting down to the tumour, and laying it bare, I found its upper and lower ends connected with a large white cord, which proved to be the median nerve. I hesitated, at first, about dividing the nerve, but concluded that it would be better to do so. Numbness of the arm, fore-arm, and fingers, particularly of the fore, middle and ring fingers, amounting almost to paralysis, followed the removal of the tumour. The wound healed kindly, however, and in a short time the general numbness disappeared, though it remained in the fingers, which were cold and almost useless for nearly three years; but, at the end of that time, was entirely removed, and the use of the fingers restored.

The second variety of neuroma has been described by Mr. Wood of Edinburgh, and by Marshall Hall, under the title of "*subcutaneous tubercle*." In all the cases detailed by Mr. Wood, the tumours were so excessively painful as to amount to agony. They were met with in different parts of the body, but generally in the extremities, and invariably occurred in females. Marshall Hall's patient, however, was a male.

The *button-like* excrescence, so often produced, by awkward and ignorant operators, in tying the extremities of nerves, along with the arteries, in wounds, and on the face of amputated stumps, has been long familiar to surgeons; but has been more pointedly noticed by the late Mr. John Bell, Hennen, and Larrey, than any other writers. The pain following the application of the ligature, under such circumstances, is intensely severe, and, in the course of time, becomes agonizing beyond endurance, and sometimes gives rise to paralysis or tetanus. The ligature, too, instead of producing the effect it does when applied to an artery, remains on the nerve, which is comparatively indestructible, for months together; and is with great difficulty pulled away, on account of the bulbous excrescence which is reared upon the end of the nerve, and is sometimes so large, as, in a case reported by Larrey, to resemble a mushroom. By some modern writers, it is said, that, in proportion as the liga-

ture compresses the nerve, lymph will be thrown out around the ligature, and that the substance of the nerve will be destroyed, and the separation of the ligature soon follow. Experience has taught me the reverse. Encysted neuroma has been noticed by Sir Everard Home, and by Swan. Epilepsy, and other diseases, have been known to follow neuroma.

Treatment of Neuroma.

Large tumours, situated among the fibrils or involving the substance of a nerve, may give rise, as already remarked, to very urgent symptoms, or may destroy the patient. On the other hand, death has followed the extirpation of such tumours, or the functions of a part have been interfered with, or materially deranged, by the division of a large and important nerve, like the ischiatic or median. There seems, however, in most cases, to be no other resource than an operation; and this we are justified in performing, upon the ground that reunion of the nerve will take place, in the course of time, (even when the intermediate portion has equalled in length two or three inches, as proved by the result of the case in which I divided the median nerve,) and that death will be almost sure to follow, if the sufferings of the patient are not speedily mitigated.

The cases of *subcutaneous tubercle*, reported by Wood and Hall, were all cured, effectually, by extirpation. Dupuytren, who has also given a minute account, so far as his description can be depended upon, of the subcutaneous tubercle, (but under the title of encysted tumour,) concurs with Wood, in the statement that females are most subject to the disease, and that extirpation is the only remedy. By Dupuytren, moreover, the disease is considered as not seated in the nervous tissue, and as liable to terminate in cancer.

Nothing less than removal of the ligature will put a stop to the extreme suffering which follows the inclusion of nerves in

wounds, aneurisms, and amputations. For months I have known the ligature to hold its place with the utmost tenacity, and the patient to be thrown into spasms upon touching the string in the gentlest manner. Even after it has been separated from the nerve, the effect will remain, in some cases, for a long time. This was strikingly evinced in the case of Captain M——, who was blown up, during the late war with Great Britain, at Fort George, and had one of the nerves of an amputated leg included in a ligature. Symptoms of tetanus came on almost immediately, and the ligature was cut away; but for months afterwards his agony was extreme, especially upon sudden atmospheric changes. On account of his sufferings, having become my patient, I tried, ineffectually, various remedies, and only succeeded, eventually, in arresting the spasms and pain, by laying open the stump and applying the actual cautery to the injured nerve. Hennen has furnished interesting cases of great distress following the tying of a nerve, and Larrey reports two fatal cases of tetanus from the same cause.

SECTION IV.

Tetanus.

A VIOLENT and extremely painful contraction of the voluntary muscles, without complete intervening relaxation, has been considered by most writers as constituting tetanus. Several varieties of the disease, differing from each other, chiefly, in situation, and proceeding from different causes, have, also, been pointed out. These are *Opisthotonos*, or a violent contraction and rigidity of the muscles of the back and posterior part of the neck, by which the body is bent backwards, or recurvated—*Emprosthotonos*, or that variety in which the body is bent forwards—*Pleurosthotonos*, or lateral inclination of the body—*Trismus*, or locked-jaw, in which the muscles of the lower jaw and throat are affected. Again; we have *traumatic* and *idiopathic* tetanus, and also the *acute* and *chronic*,—the former proceeding from wounds, the idiopathic from various causes, while the terms acute and chronic are intended to denote the period and duration of the attack.

Of these varieties, however, the *opisthotonos* is, by far, the most common, and whether the result of a wound, or of cold, or any other cause, is characterized by the following symptoms:—painful rigidity of the neck, resembling rheumatism, difficulty of deglutition, followed by inability to swallow liquids, and in attempting so to do, by spasms in the throat. To these succeed, sooner or later, violent spasmodic, lancinating pain, which shoots, with the rapidity of lightning, through the chest, from the sternum to the spine, recurs at shorter and shorter intervals, and is augmented, at last, to an intolerable degree of intensity. With this peculiar symptom, which is strikingly characteristic of the disease, the contraction of the

muscles of the neck, back, and jaw, keep pace; the head, in particular, is thrown painfully backwards, and cannot be restored to its natural position, the breathing is interrupted by the action of the muscles of the neck on the windpipe, the pulse is fluttering, small and quick, the face flushed, the forehead wrinkled, the eyes turned upwards or distorted, the nostrils dilated, and the whole countenance greatly distressed. At last every voluntary muscle of the body appears more or less implicated; those of the abdomen are drawn up into knots, and the whole belly feels as hard as a board. In proportion as the spasmodic contractions increase, the head and lower extremities approach each other in a backward direction, so that the body forms an arch towards the bed, whilst its anterior parts assume the convexity of the segment of a hoop—the weight of the body being sustained upon the head and heels. By this time the jaws become immoveably fixed; but sometimes are occasionally relaxed in a slight degree, and then suddenly snap together with a convulsive jerk, which has been known in some instances nearly to sever the tongue, which is very apt to be protruded, at every stage of the disease, beyond the lips. The patient is scarcely a moment free from the most agonizing spasms; but, notwithstanding his extreme suffering, the intellect remains unclouded to the last, and the pulse scarcely ever amounts to the height of fever. In general, sudden and violent convulsions terminate the scene.

Traumatic tetanus may follow the most insignificant scratch, in some instances, and in others, cannot be produced by the most extensive laceration. Occasionally it shows itself almost immediately, and, in other cases, does not come on until the wound is entirely healed. In general, however, it makes its appearance before the tenth day, and, where there is a tendency towards the disease, may be induced in a very short time by exposure to cold, or to a stream of cold air, even in the hottest weather. It is most common in warm climates, and in the summer months. Wounds in the palms of the hands or fingers, and especially in the soles of the feet and toes, are most apt to give rise to it. That it derives its origin from wounded filaments, or trunks of nerves, rather than from wounds of *tendons*, (as formerly imagined,) there is every reason to believe; for several cases have been reported where foreign bodies have been

found lodged in the substance of nerves, and where wounds have been traced to one or more branches. On the other hand, it must be confessed, that dissection has been frequently unable to reveal to us the source of this inexplicable, and most formidable malady.

Treatment of Tetanus.

In the treatment of tetanus, the prospect of success will depend much upon the cause of the disease. When it arises purely from cold, from vegetable and other poisons, and is chronic, instead of acute, recovery often follows, even under the most opposite modes of treatment. But *traumatic* tetanus, generally, defies the most vigorous and skilful efforts of the surgeon. So far as my own experience goes, I am inclined to rely, mainly, and from the first, upon very large doses of opium. Twenty years ago I attended, along with Professor Baker, of Baltimore, a boy, seventeen years of age, who, from being precipitated from a scaffold, amidst a pile of bricks, had the bones of the forearm fractured about the middle, dislocated at the wrist, and protruded some inches. Tetanus followed in four or five days, and, as soon as its approach was announced, we commenced with opium in very large doses. Perceiving at once an amelioration of symptoms, the remedy was persevered in, and directions left with the mother of the boy to pour down laudanum, during our absence, whenever she perceived the spasms to come on. Our instructions having been rigidly adhered to, and the opiate exhibited almost without reference to quantity, the system of the patient became so saturated with the medicine that a perfect cure was effected, although the spasms continued, with more or less severity, for six or eight weeks. At one period of the disease, the boy took four, and sometimes five, hundred drops of laudanum in twenty-four hours. In a few other cases I have since succeeded in effecting cures by similar means; but,

in the majority, have totally failed, in spite of opium in immense doses, and every other remedy that could be thought of. In one case of traumatic tetanus, under care of my friend, Dr. Antrim Foulke, a most respectable practitioner of Montgomery county, with whom I saw the patient about three years since, a cure was effected through the medium of large quantities of opium and asafoetida. But the same treatment, although rigorously pursued, during the last summer, in a case which I attended with Dr. I. G. Nancrede of this city, was productive of no benefit whatever. As a general rule, poultices should be applied to the wound, in order to excite the suppurative action, both in cases where we have reason to apprehend tetanus, and after that disease has come on.

The other remedies employed in tetanus, general as well as local, and still relied upon by some practitioners, may be barely enumerated. These are, the warm and cold bath, ardent spirits and wine, mercury, sudorifics, musk, volatile alkali, purgatives, elatereum, prussic acid, colchicum, electricity, tobacco enemata, turpentine, blood-letting, sub-carbonate of iron, digitalis, camphor, amputation, caustics and the actual cautery to the wounded part, or along the spine.

Consult *The Nervous System of the Human Body*, by Sir Charles Bell, 4to. London, 1830—*Swan on Diseases and Injuries of the Nerves*. London, 8vo. 1834—*Dissertation sur les Affections Locales des Nerves*, par P. J. Descot. 8vo.—*On Painful Subcutaneous Tubercle*, by William Wood, in *Edinburgh Medical and Surgical Journal*, vol. 8, p. 238—*Case of Painful Subcutaneous Tubercle*, by Marshall Hall, *ibid.* vol. 11th, p. 466—*An Account of an uncommon Tumour formed in one of the Axillary Nerves*, by E. Home, in *Transactions of Medical and Chirurgical Society*, vol. 2d, p. 152—*C. Bell's Operative Surgery*, vol. 2, p. 331—*Of Nervous Ganglions, or Tubercles*, by Baron Dupuytren, in *Clinical Lectures on Surgery*, translated by Doane, 8vo. Philad. 1833—*Remarks on Tic Douloureux, with Cases*, by N. Chapman, in *Amer. Jour. of Med. Sciences*, No. XXVIII: 1834.

On Tetanus, consult *Larrey's Memoires*—*Hennen's Military Surgery*—*Sir James M^cGrigor, in Medico-Chirurgical Transactions*, vol. 6—*Cooper's Surgical Essays*, &c.

CHAPTER XVI.

AMPUTATION.

FROM the earliest periods the question of the propriety or impropriety of amputation, in certain diseases and injuries, has been agitated with warmth, and even with acrimony—some contending that the operation was scarcely ever necessary, under any circumstances—others, that patients were often suffered to die for want of it. Unfortunately, these points are almost as unsettled at the present day, as at any former period; and so long as the constitutions of patients continue to differ, and the circumstances favourable, or unfavourable, to their recovery vary, it will, perhaps, be impossible to lay down definite rules adapted to every case. Still, however, much may be pointed out as approaching to certainty, and the rest must be left to the discretion and experience of the surgeon.

The injuries and diseases for which amputation may be required, may be arranged under the following heads:—1st, Gun-shot wounds and fractures. 2d, Mortification. 3d, Tumours. 4th, Diseased joints. 5th. Ulcers.

Military surgeons have been often accused of amputating limbs unnecessarily; but it should be remembered, that after a battle the wounded are liable to be hurried from post to post, and in carts or wagons, for days together. Under these circumstances, the patient would not only suffer immense pain, but his life, in many instances, be sacrificed. The military surgeon, aware of this, amputates the limb on the field of battle, or as soon as possible

afterwards, and dresses the stump. Thus situated, the patient may be moved about, with comparative ease, and with considerable prospect of eventual recovery. In civil life, on the contrary, with every convenience and comfort at hand, the removal of the limb, except in extreme cases, would be considered improper and unjustifiable. The distinction, therefore, should always be drawn between the two cases.

In all gun-shot and other wounds, whether accompanied with fractures or not, the first object of the surgeon should be to decide at once upon the treatment. As a general rule it may be observed, that if the chief arteries of a limb are divided, the muscles lacerated, and the bones broken, there can be no question concerning the propriety of amputation. On this point all surgeons of the present day entertain but one opinion. When the injury is less extensive, a question will necessarily arise how far the surgeon may be authorized in risking the patient's life, in order to save his limb. This can, of course, only be determined by the peculiarity of the case; but experience, or the termination of former cases, will be the best guide. If a musket ball, for example, pass through the fore-arm, and the radial and ulnar arteries escape, amputation will seldom be required. On the contrary, if the ball should penetrate the wrist and fracture the bones, the operation will, in most cases, prove necessary. Wounds and fractures of the carpus, metacarpus, and metatarsus, rarely require amputation; but similar injuries of the tarsus, or of the ankle joint, almost invariably terminate unfavourably, unless amputation be performed. The same may be said of gun-shot injuries of the fingers and toes, from which tetanus is extremely apt to ensue. When balls lodge deeply in the tibia, when both bones of the leg are fractured, and their arteries at the same time are wounded, and when the injury has been inflicted upon the extremities of the bones, near the knee or ankle joints, nothing less, in most instances, than amputation will save the patient. Gun-shot wounds of the knee, elbow, and shoulder joints, almost without exception, prove fatal, unless a timely removal of the limb be resorted to. Gun-shot fractures of the thigh bone are so extremely hazardous, that very few patients recover from them. Much will depend, however, upon the situation of the fracture. If the bone is broken below its middle, the necessity for amputation will not be so urgent, and perhaps a cure

may take place without this operation. When the upper portion of the bone, however, is fractured, recoveries very rarely follow, owing to the shock communicated to the system, and to the high fever, and extensive abscesses which form among the muscles of the hip and thigh.

Admitting the above statements, however, to be correct, (and they correspond with the views of the best modern writers,) another question will naturally present itself:—At what period should the operation be performed? On this subject, a great diversity of opinion has prevailed; some contending, that immediate amputation, in the severer injuries, is indispensable; others, that a secondary operation is more likely to be attended by a favourable result. If the weight of authority may be deemed sufficient to settle the question, the number of advocates for immediate amputation, will be found greatly to exceed that of its opponents. Among the former may be enumerated the names of Ledran, Boucher, Ranby, Pott, Schmucker, Mursinna, Boy, Percy, J. Bell, Larrey, Graefe, Guthrie, Thomson, and Hennen—among the latter, Faure, Martiniere, Hunter, and Lombard. When *immediate* amputation, however, is spoken of, it must not be understood that the operation is to be performed instantaneously, or as soon as possible after the injury. On the contrary, it is agreed, upon all hands, that the surgeon should wait until *reaction* takes place, and that, after this, the sooner the operation is performed the better; inasmuch as symptoms of inflammation may afterwards be expected to supervene; and if the operation be performed during this stage, the patient's chance of recovery will be very much diminished. As regards the period at which reaction occurs, after injuries, this will depend altogether upon the extent of the injury, and the peculiarity of the patient's constitution. Some will recover from the shock communicated to the system in an hour or two; others will remain twelve or fifteen hours with a cold skin and feeble pulse. So long, therefore, as these symptoms continue, it may be repeated, the operation must not be undertaken; otherwise, the patient will be apt to die on the table, or a few hours after he is removed from it. Whenever the patient has so far recovered from the injury that his pulse becomes regular, his countenance lively, and he begins to complain of pain and stiffness in the part, this will be the most favourable period for

the operation. Provided the operation be performed within forty-eight hours after the injury, it has been customary for military surgeons to denominate it *primary* amputation. On the contrary, when it is delayed until the symptomatic fever has lessened, and the suppuration is copious, it is called *secondary* amputation.

From what has been stated, it will appear that amputation should be performed, in all those cases where the operation seems to be inevitable, before the accession of inflammation, and as soon as possible after reaction is completely established; but in slighter injuries, such as would seem not imperatively to demand the operation, and under circumstances calculated to favour the patient's recovery, it will become the duty of the surgeon to attempt to save the limb—calculating, if he should be disappointed in his expectation, upon *secondary* amputation as a resource. It should never be forgotten, however, that an operation, performed after the limb has passed through the stages of inflammation, cannot, in general, prove so successful as the primary one, because the muscles, cellular membrane, blood-vessels, and bone, have all taken on more or less disease. Independently of this, secondary amputation, performed upon soldiers who are crowded together in ill-ventilated hospitals, is apt to terminate unfavourably, either from the stump being attacked by hospital gangrene, or from the prevalence of some epidemic disease. But one of the strongest objections that I know of to delay, and which has been particularly pointed out by Mr. Guthrie, is this: "When an amputation," says he, "is delayed from any cause, to the secondary period, a joint is most frequently lost; for instance, if a leg be shattered four inches below the knee, it can frequently be taken off on the field of battle, and the joint saved. Three or four weeks afterwards, the joint will, in all probability, be so much concerned in the disease, that the operation must be performed in the thigh; the same in regard to the fore-arm and hand, and the upper part of the arm with the shoulder joint. This is a very important point for the consideration of military surgeons, in recommending delay in doubtful cases, as well as the knowledge that amputations in unsound parts are frequently fatal, and are always attended with danger." I might detail numerous cases that have fallen under my own care or notice, in proof of all the

foregoing positions relating to amputation as a resource in gun-shot injuries; but so many of the kind are detailed in the works of military surgeons, as to render the relation unnecessary.

Mortification, when it attacks the extremities, may require amputation. But it has long been an established maxim among surgeons, not to operate for this disease during its progress, or until a line of demarcation has been formed, and the dead parts are about to separate from the living—when an amputation will become necessary to form a proper stump, and to remove the bone. If, as experience has proved, in innumerable cases, the surgeon were to apply the knife while the disease was advancing, no benefit would result, as the mortification would attack the stump, and continue to increase until it spontaneously ceased, or destroyed the patient. There are certain cases, however, in which it would be proper to deviate from this course, and perform the operation, notwithstanding the progression of the disease. If, for example, gangrene, from a gun-shot injury, has seized upon the leg, and is rapidly extending along the thigh towards the body, the patient's chance of recovery will at any rate be small, and under these circumstances, it is possible, though not very probable, that the removal of the thigh may save his life. At all events, the operation should be tried, because it has sometimes proved successful, where death, without it, would speedily have happened. There is another case, also, in which it will be proper not to wait for the line of separation. It is this. A man is shot through the thigh, the femoral artery and vein torn across, and being yet able to walk about, his wound is considered a slight one. About the third or fourth day, however, the toes and foot are found discoloured, and the limb cold and painful. The nature of the disease is then rendered evident, and if not speedily arrested by amputation above the wound, will soon have a fatal termination. For a knowledge of this fact, the profession is particularly indebted to Mr. Guthrie. Notwithstanding the axiom that amputation should not be performed during the progress of mortification in ordinary cases, it is proper to state that Larrey, Hennen, Hutchinson, Lawrence, and some other distinguished surgeons, have long been in the habit of deviating from the rule, and, according to their accounts, with considerable success.

There are many *tumours*, most of which have been noticed

in the preceding pages, that may require, (if they attain a large size, and seriously affect the patient's constitution,) amputation. These are, osteo-sarcoma, spina ventosa, exostosis, fungus hæmatodes, &c. The latter disease, as formerly stated, invariably proves fatal, unless arrested by a timely amputation, and, indeed, in many instances, this will not ensure the patient's life, even when resorted to in the very commencement. Formerly, many limbs were sacrificed on account of aneurismal tumours, but the improved methods of treating that disease, may be said to have exploded the practice of amputation in such cases.

White swellings, as they are called, when neglected, or improperly treated, by exhausting the patient's constitution through the medium of hectic and diarrhœa, often prove fatal. To remove this constitutional disturbance, and to save the patient's life, amputation, in many instances, will, unfortunately, become necessary; and its benefit is surprisingly evinced upon many occasions, by the rapid amendment of the patient's general health, and early cicatrization of the wound. But there is reason to believe that the operation too often becomes a dernier resource, rather from the mismanagement of the surgeon, than the intractable nature of the complaint.

In civil life, old and inveterate *ulcers of the leg* very frequently call for the removal of the limb; and upon such occasions, the practice of amputation is, perhaps, as justifiable as in most other surgical diseases; for after having, for years, exhausted the resources of his art, the surgeon will find that the constitutional irritation and disturbance will carry off his patient, unless he can eradicate them by laying the axe at the root of the evil. There is one error, however, that an inexperienced surgeon may commit upon these occasions, and which it will be proper to point out. It may happen that an incurable ulcer, accompanied by diseased bone, has existed for years, and has served in bad constitutions, especially the old and debilitated, as an issue or drain, which so long as it is kept open, tends to appease a cough or some other troublesome symptom. If, under these circumstances, amputation be performed, and the stump heal up, the patient, perhaps, in a short time, recovers his plumpness, and gets apparently well; but in the course of a few months, evident disorder of some of the internal organs, and of the lungs especially, shows itself, and death, in a short

time, follows. I have witnessed too many examples of this sort, not to be fully aware of the danger of an amputation, when thus improperly performed. Mr. Guthrie, Dr. Hennen, and some other writers, notice such consequences, sometimes following secondary amputations, after gun-shot wounds.

The *instruments* and *dressings* required for most amputations, are two amputating knives, one rather larger than the other, a catling, two or three scalpels, the same number of tenacula, artery forceps, needles, ligatures, sponges, a large and small saw, bone nippers, two tourniquets, compresses, rollers, linen retractors, a Malta cross, lint, tow, adhesive straps, lint spread with cerate, two or three basins of warm water, wine and water in a tea-pot.

Formerly, amputating knives, extremely concave on the cutting edge, were employed. The modern knife is nearly straight, rather short, but substantial in the blade, and rough on the handle, to enable the operator to take a firm hold. The catling is a narrow, two-edged knife, tapering away to a point, and bears a strong resemblance to a dirk. It is intended to pass between bones, and separate the soft parts adhering to them. The amputating saw is about the size of a carpenter's dove-tail saw, and its handle should also resemble, in some respects, that of the latter. The blade should be thinner as it approaches the back of the instrument, the teeth widely set, and so constructed as to cut with both edges as they are passed backwards and forwards. In using the saw, the surgeon will discover, after a little practice, that the instrument works to the best advantage when moved steadily by long strokes, always taking care to commence by applying the heel of the instrument first to the bone, and drawing thence to the point. When the bone is nearly cut through, the operator should move the saw cautiously and gently, lest the bone suddenly break and leave a projecting point or snag. When this happens, however, it is commonly owing to the assistant not supporting the limb with steadiness. The *bone nippers* are designed to remove the projecting portion of bone, should it break, and are well calculated for the purpose. The handles of this instrument should be longer than they are usually made, and its cutting part placed obliquely upon the shafts. *Retractors* are made of linen, cotton, leather, and sometimes of metal in the form of plates; but the linen are the best.

They are formed, by taking a piece of linen, eighteen inches or two feet in length, and a little broader than the stump, and dividing it along the middle ten or twelve inches. The use of the retractor is to draw up the muscles after they are divided, and prevent them from being torn by the teeth of the saw. The *Malta cross* is formed by sewing two pieces of a linen or cotton roller, each about two feet long, across each other at the centre. It serves the purpose of confining the lint or tow upon the front of the stump, and, in this way, assists the roller. A piece of lint, spread with cerate, and large enough to cover the whole stump, will always be found extremely useful in preventing the ends of the ligatures from being glued to the surrounding dressings, by the matter that escapes from the wound. As the patient will have frequent occasion for drink during the operation, and cannot conveniently take it from a tumbler, whilst lying on his back, the spout of a teapot, or some similar vessel, applied to his lips, will be found to answer a better purpose than any thing else.

SECTION I.

Amputation of the Thigh.

THE patient being seated on the edge of a strong table, with his back supported by pillows, and assistants on each side to take charge of his hands and arms, the tourniquet is applied by an assistant, about three inches below the groin—a small compress of muslin being previously placed under the frame of the tourniquet, while the pad of the instrument is fixed above the femoral artery. Having ascertained that the circulation of the blood in the limb is interrupted by the pressure of the tourniquet, the surgeon directs an assistant to elevate the leg, and support it nearly in the horizontal position, and then carrying

the amputating knife under the limb, until it nearly reaches the side on which he stands, applies it to the thigh as low down as the disease will admit, and with one continued sweep divides by a circular cut, the integuments, fat and fascia. The large knife is then exchanged for a scalpel, with which the operator separates the loose cellular membrane connecting the integuments to the muscles, and turns back the skin to the extent of two inches, in the same way that one would turn back the cuff of a coat. Having resumed the amputating knife, and keeping it close to the rounded margin of the reverted integuments, the surgeon next cuts through the muscles down to the bone. In making this incision, the edge of the knife should be inclined upwards, in order, as it were, to hollow out the front of the muscles in the form of a cone. With the scalpel, the surgeon separates the muscles from the bone for two or three inches, after which, an assistant applies the slit of the retractor around the bone, twists its ends together, and forcibly pulls the muscles upwards. The bone is next divided by the saw, and the limb removed. A soft sponge is applied to the surface of the stump, and the blood being cleared away, the femoral artery, enclosed by its sheath, and lying near the bone, may be distinctly seen. With a tenaculum, it is drawn out, separated from its accompanying nerve, and tied with a strong round ligature. After this the assistant slackens the tourniquet slightly, when a jet of blood will generally be perceived from some of the branches of the profunda and other arteries. These vessels must likewise be taken up successively, until the whole are secured. But often it happens that the vessels, from an approach to syncope, retract, and for a time do not bleed. The surgeon, aware of this, must not be too hasty in closing the stump, but should rouse the arterial action by wine and water, the admission of fresh air into the room, and solicit, gently, the extremities of the vessels on the stump, by warm water and the sponge. As soon as all danger of secondary hemorrhage is over, the stump may be dressed. The ligatures being brought out of the upper and lower corners of the wound, its edges are pressed together by an assistant, in such a way as to cover completely the extremity of the bone, and form a cushion for it out of the cut muscles and integuments. While thus held, the surgeon carefully wipes the surface of the skin, for several inches around, so as to render

it perfectly dry and fit to receive the adhesive straps, which are next warmed and applied—with interspaces of half an inch between them.* Over the straps is laid the cerate plaster, and above the plaster a thick pledget of tow. This last, in its turn, is secured by the Malta cross, and the ends of the latter fastened down by a roller, made to cover by circular turns the whole thigh, and kept from slipping downwards, by being carried once or twice around the patient's pelvis. The tourniquet being applied loosely about the limb, (that it may be suddenly screwed in case of secondary hemorrhage,) the patient is put to bed, laid on his back or side, and the stump supported by a pillow, and, secured to it by pins and short strips of muslin. Over the stump is placed a frame to take off the weight of the bed clothes. If the patient is to lie on his back during the cure, the edges of the wound should be put together so as to form a perpendicular cicatrix, to allow the matter greater facility of draining off. On the contrary, should he be confined to his side, the edges must be approximated in a horizontal direction. During winter, the dressings may remain on seven or eight days, but in summer only two or three. They should be poulticed three or four hours previously to attempting their removal. The *after* dressings may be repeated once in forty-eight hours. About the tenth day, the ligatures usually come away, and under favourable circumstances, the wound is healed in three or four weeks.

To prevent corners from being left, at the upper and lower angles of the wound, in consequence of the integuments being puckered in these situations, an inevitable consequence of the circular incision, as practised in the operation I have just described, Professor Davidge, of Baltimore, has long been in the habit of making his incision through the skin with a common scalpel, deviating above and below from the circular direction, and forming an angle which serves the purpose of rounding off the corners. The operation is not only neater than the ordinary one, but possesses an advantage over it as regards the facili-

* To prevent the edges of the skin from uniting by the first intention, and before the wound closes from the bottom, and thereby to guard against the accumulation of pus beneath the integuments, Dr. Physick has been in the habit of sometimes interposing a bit of lint between the lips of the wound, and keeping it there for a few days.

ty of escape of the matter, which, instead of collecting in a pocket, formed by the pouting integuments, drains off as soon as secreted. It may be proper to observe, however, that after the stump has *healed*, the corners, (which always exist immediately after the common operation,) disappear, and do not subject the patient to any inconvenience.

SECTION II.

Amputation of the Leg.

As much as possible of the thigh, should, in all cases, be saved, but the rule does not always hold good in amputation of the leg. If, for example, the leg be amputated just above the ankle, the bone, from the deficiency of surrounding muscle, cannot be well covered, and is, therefore, not calculated to bear the pressure of an artificial leg. On this account, the patient is obliged to have an instrument of the kind adapted to the knee, and the leg, therefore, is carried out behind at right angles with the thigh, and by its weight greatly incommodes the patient—so much so, indeed, that I have known several submit to a second operation, for no other reason than to get rid of the incumbrance.

It is usual with surgeons, in amputating the leg, to perform the common circular operation, when it is desirable to take off the limb a few inches below the knee, and the *flap* operation when the leg is removed just above the ankle. I prefer the latter, however, in all cases. It is done as follows:—The tourniquet being placed about the middle of the thigh, the leg is supported by an assistant holding at the foot, the surgeon calculates beforehand the quantity of soft parts that may be required to cover the bone, and passes the common amputating knife obliquely upwards on the back part of the leg through the skin, which being drawn up by an assistant, the knife is next carried along the margin of the divided skin, through the muscles to the bone, then perpendicularly over the tibia, until it meets the oblique cut on the other side of the leg. The catling is next thrust between the bones, and the muscles and interosseous

membrane divided, a retractor with *three* tails introduced, the integuments and muscles drawn up, and the bones sawed off. The arteries being carefully tied, and the nerves excluded from the ligature, the flap formed out of the muscles and skin is turned up in front of the bones, and forms over them a thick cushion, calculated afterwards to bear the pressure of a wooden leg. In dressing the stump, however, (in the way recommended for the thigh,) care should be taken not to press the flap too forcibly against the sharp edges of the tibia—lest ulceration be excited.

SECTION III.

Amputation of the Arm and Fore-arm.

WHEN it becomes necessary to amputate the arm, the patient should sit on a chair, or lie over the edge of a bed, and while the limb is carried out at right angles with the body, and supported by an assistant, a circular incision is made through the skin and muscles, (according to the directions already given when treating of amputation of the thigh,) the bone sawed off, the vessels secured, and the dressings applied. If the operation is performed about the middle or the lower part of the arm, the tourniquet may be applied above; but when it becomes necessary to amputate very high up, there will be no space left for this instrument, and the surgeon must then trust to compression of the subclavian artery, where it passes over the first rib. Under these circumstances, Larrey, and some other surgeons, advise the amputation of the arm at the shoulder joint; but I should prefer making a flap out of the deltoid muscle, and with this covering the extremity of the bone.

Amputation of the fore-arm may be performed either by the common circular incision, or by the flap. The former, in most cases, will answer extremely well, and, as being more simple than the flap operation, should be preferred. As much of the fore-arm as possible ought to be preserved.

SECTION IV.

Amputation at the Shoulder Joint.

By a cannon-shot, the head of the os humeri is sometimes carried away, or the bone so shattered, as to render amputation at the shoulder joint necessary. The same may be said of fracture from a bullet or grape-shot. Various tumours, also, such as fungus hæmatodes, exostosis, &c., may give rise to this operation, which was formerly looked upon, under any circumstances, as hazardous in the extreme. The experience, however, of modern military surgeons, tends to prove its perfect safety as well as simplicity. There are various modes of performing the operation; but the old plan of La Faye, as modified by later operators, should, I think, in most cases, be preferred. It is executed in the following way:—

The patient is seated on a chair, whilst an assistant, standing behind him, presses on the subclavian artery, where it passes over the first rib, by a boot hook, or large key, covered with a firm linen compress. A semicircular incision, with its convexity downwards, is then made, transversely with a large scalpel, through the integuments and deltoid muscle to the bone, three or four inches below the acromion process. This flap being turned upwards, the tendon of the long head of the biceps is exposed and divided, the capsule of the joint opened, and the head of the bone turned out of its glenoid cavity. As soon as this is accomplished, the soft parts beneath the arm are cut through, at a single stroke of the knife, the arm separated from the body, and the axillary artery instantly picked out by the tenaculum and tied. Any other vessels that may bleed being secured, in like manner, the edges of the wound are brought together, and dressed in the ordinary way. But it sometimes happens that

the deltoid is shot away, and of course the surgeon cannot depend upon it for a flap. In that case the glenoid cavity may be covered by the muscles on the sides or under part of the arm. I have twice, only, found it necessary to amputate at the shoulder joint.

In certain cases it may be possible to save the patient's arm, notwithstanding a gun-shot wound and fracture of the head of the humerus—by laying open the joint immediately after the injury, and removing the fragments of bone, or by waiting until suppuration is established, and the shattered pieces become loose. An operation of the kind, however, can only be depended upon when the fracture is comparatively limited, and the shaft of the bone not splintered. Baron Larrey, Mr. Guthrie, and other surgeons, have repeatedly succeeded, under these circumstances, in preserving the limb, and saving the patient's life.

SECTION V

Amputation at the Hip Joint.

THIS is, perhaps, the most formidable and terrific operation in surgery; yet there are several examples on record of its successful termination; though it must be confessed that it has failed in an immense number of cases. Having never performed the operation, I cannot from experience speak of the best mode of executing it, and shall therefore give it in the words of Mr. Guthrie, whose method, it seems to me, has at least simplicity to recommend it.

“The patient should be laid on a low table, or two field panniers placed together, covered with a folded blanket, to prevent the edges giving pain, and properly supported in a horizontal position. An assistant leaning over, and standing on the outside, should compress the artery against the brim of the pelvis, with a firm, hard compress of linen—such as is usually used before the tourniquet; he should also be able to do it with his thumb, behind the compress, if it be found insufficient. The surgeon standing on the inside, with a strong pointed amputating knife of a middle size, with the back curved, makes his first incision through the skin, cellular membrane, and fascia, so as to mark out the flaps on each side, commencing about four fingers’ breadth, and in a direct line below the anterior superior spinous process of the ilium, in a well-sized man, and continuing it round in a slanting direction, at an almost equal distance from the tuberosity of the ischium, nearly opposite to the place where the incision commenced. Bringing the knife to the outside of the thigh, he connects the point of the incision where he left off with the place of commencement, by a gentle curved line, by which means the outer incision is not in extent more than one-third of the size of the internal one. The integuments having retracted, the glutæus maximus is to be cut from its insertion in the linea aspera, and the tendons of the glutæus medius and minimus from the top

of the trochanter major. The surgeon now placing the flat edge of the knife on the line of the retracted muscles of the first incision, cuts steadily through the whole of the muscles, blood vessels, &c., on the inside of the thigh. The artery and vein, or two arteries and vein, if the profunda is given off high up, are to be taken between the fingers and thumb of the left hand, until the surgeon can draw each vessel out with the tenaculum, and place a ligature upon it. Whilst this is doing, the assistants should press with their fingers on any small vessels that bleed. The surgeon then cuts through the small muscles running to be inserted between the trochanters, and those on the under part of the thigh, not yet divided; and with a large scalpel opens into the capsular ligament, the bone being strongly moved outwards, by which its round head puts the ligament on the stretch. Having extensively divided it on the fore and inside, the ligamentum teres comes into view, and may readily be cut through. The head of the bone is now easily dislocated, and two or three strokes of the knife separates any attachment the thigh may still have to the pelvis. The vessels are now carefully to be secured. The capsular ligament, and as much of the ligamentous edge of the acetabulum may be removed as can readily be taken away. The nerves, if long, are to be cut short, the wound well sponged with cold water, and the integuments brought together in a line from the spinous process of the ilium to the tuberosity of the ischium. Three sutures will in general be required, in addition to the straps of adhesive plaster, to keep the parts together: the ligatures are to be brought out in a direct line between the sutures, a little lint and compresses are to be placed over the wound, and on the under flap, to keep it in contact with the cotyloid cavity, and assist the union of the parts. A piece of fine linen is to be laid over them, and the whole retained by a calico bandage put around the waist and brought over the stump.”*

Amputation at the hip joint, can never be required, perhaps, except for a gun-shot wound, or some similar extensive injury, in which the muscles, large vessels, and nerves, are lacerated, and the head, neck, or superior part of the thigh bone, or part of the pelvis are crushed. Such effects generally arise from cannon, or grape-shot, or from the bursting of shells, and from machinery in motion.

* Guthrie on Gun-shot Wounds of the Extremities, p. 178.

SECTION VI.

Amputation of the Fingers and Toes.

WHEN the hand and fingers are shattered by the bursting of a gun, by grape-shot, bullets, by machinery, or any other cause, amputation will often become necessary, in order to guard against tetanus, and the effects of inflammation. Where it can be done, however, without risking too much the patient's life, an attempt should always be made to save, at any rate, one or more fingers, as the patient will find them, even when mutilated, extremely useful. In such cases, the mode of operating, must depend very much upon the extent and shape of the wound and fractures. Instead of using the spring saw contained in most amputating cases, when the metacarpal bones are injured or diseased, and require extirpation, the semicircular trephine, of Sir Charles Bell, will be found the most convenient instrument for removing the bone. Fingers and toes are, generally, amputated at the joints, and the following is the mode of performing the operation, as usually practised.

Whilst an assistant draws up the skin, the surgeon makes a circular incision three or four lines below the joint. The skin is next separated and turned back, the tendons surrounding the joint divided, the finger or toe bent so as to render the joint more conspicuous, the capsular and lateral ligaments cut through, and the extremity removed. It is seldom necessary to take up any vessels, but the oozing of blood should be allowed to stop, after which the surgeon may draw together the edges of the skin, so as to cover the end of the bone, and retain them by strips of adhesive plaster, and a narrow roller.

Many attempts have been made, of late years, by Lisfranc, in particular, and other French surgeons, to modify and improve the operation of amputation. With very few exceptions, their methods have not been found to answer on the living subject, however neat and advantageous they may have appeared on the dead.

On Amputation, consult *Pott's Works*, vol. 3—*Hey's Practical Observations*, edit. 3—*Desault's Works*, by Smith, vol. 1—*J. Bell's Principles of Surgery*, vol. 1—*Larrey's Military Surgery*, by Hall, vol. 1 and 2—*C. Bell's Operative Surgery*, vol. 2—*Guthrie on Gun-shot Wounds of the Extremities*—*Thomson's Report of Observations made in the Military Hospitals in Belgium, after the Battle of Waterloo; with some Remarks upon Amputation*—*Pelletan Clinique Chirurgicale*, tome 3—*Hennen's Principles of Military Surgery*, edit. 2—*C. Bell's Surgical Observations*—*Dorsey's Surgery*, vol. 2, edit. 3—*Coster's Manual of Surgical Operations*, by Godman, Philad. 1825—*Liston's Elements of Surgery*, Ed. 1832—*Article Amputation*, in *Dictionnaire des Sciences Medicales*, tom. 1—*Velpeau Nouveaux Elements de Medecine Operatoire*. Paris, 1832—*Geddings*, in *Cyclopædia of Practical Medicine and Surgery*, a digest of Medical Literature, by Isaac Hays, M. D., article *Amputation*.

CHAPTER XVII.

HYSTEROTOMY OR CÆSARIAN SECTION.

IN cases of extraordinary diminution, or deformity, of the pelvis—of exostosis, and other tumours within its cavity—of fractures of the innominata and sacrum, followed by irregularity of reunion or profusion of callus—of dislocations of one or both thigh bones—of wounds of the uterus—of extraordinary size of the fœtal cranium—of fœtal monstrosity—of hernia of the uterus—of preternatural presentation of the fœtus—of rupture of the uterus—of obliquity of the uterus—of large stones in the bladder—of strictures and adhesions in the vagina—of enlargement of ovaries—of extra-uterine conceptions, and other diseases, accidents, malformations, or death of the mother, it may become necessary to lay open the parietes of the abdomen, divide the peritoneum, cut into the womb, and remove the child. From the earliest periods the operation has been resorted to, with more or less success, in some countries, and in others with total failure. Thus, in Great Britain, although performed between thirty and forty times, there is not a single instance in which both mother and child have been saved, and very few, where the life of the infant alone has been preserved. In France, Germany, and some other parts of the continent, however, the operation has frequently proved successful, and has been repeated on the same patient with similar result. Indeed, out of two hundred and thirty-one operations reported, one hundred and thirty-nine are said to have been followed by partial, or complete, success. That the operation has been attempted, by

surgeons, two or three times in the United States, there is reason to believe; but in no instance has the life of mother and child, so far as my information extends, been saved except in the case I shall now relate.

Mary R——d, wife of Joshua M. R——d, Esq., of this city, 26 years of age, was married, the 16th of May, 1830, and on the fourteenth of June, 1831, was in labour with her first child. Dr. George Fox, being called to her assistance, found the os uteri sufficiently dilated to admit a finger, and feel the protruding membrane. Discovering, a few hours afterwards, great deformity of the pelvis, he was led to believe that Mrs. R. could not be delivered per vias naturales, and, therefore, requested the assistance of Professor James, and subsequently, that of Drs. Meigs, Lukins, Hewson and J. R. Barton. After repeated, and most accurate examination, it was concluded that the antero-posterior diameter of the pelvis did not exceed two inches; and it then became a question, whether the division of the symphysis pubis, the Cæsarian operation, or embryotomy, should be performed. "The Cæsarian operation was thought to be attended with so much risk to the mother as almost to be necessarily fatal, some of the most distinguished surgeons being decidedly opposed to its performance; and Dr. Physick, who was called upon for his opinion, on the propriety of this operation, was decided, and positive in his opposition to it. Under the weight of such authority, the idea of the Cæsarian operation was abandoned."* It was then determined to perform cephalotomy, and Dr. Meigs agreed to undertake it. Before he commenced that operation, however, Dr. M., conceiving, after further examination, that "cephalotomy would be attended with as much risk to the life of the mother as the Cæsarian operation, thought it better to call another consultation, to reconsider the propriety of performing the Cæsarian operation."† During this consultation it was decided that the child was dead; there being, therefore, "no further hesitation as to the propriety of cephalotomy," that operation was commenced immediately by Dr. Meigs, and performed in the most

* Relation of a case of labour, in a female with deformed pelvis, by George Fox, M. D., in *North American Medical and Surgical Journal*, No. xxiv. October, 1831, p. 485.

† Ibid.

skilful manner, and the patient, (notwithstanding the great difficulties the operator had to encounter,) recovered in three weeks after delivery, though she had almost fallen a victim to exhaustion.”*

On the 22d of June, 1833, Mrs. R’s. labour with her *second* child commenced. Dr. Meigs was again called to her assistance, and performed a second time the operation of cephalotomy—having previously ascertained that Cæsarian section would not be submitted to. The patient again recovered, and with less difficulty than after the first operation.

In June, 1834, Mrs. R——d became pregnant with her third child, and my friend Dr. Jos. G. Nancrede, now one of the oldest and most respectable accoucheurs of this city, was consulted, and after mature deliberation decided, that Cæsarian section was the only appropriate operation in her case, inasmuch as it had been performed on the continent of Europe, in numerous instances, with success, and was considered by the most eminent accoucheurs not more hazardous, under certain circumstances, than embryotomy. Upon these and other grounds, Dr. Nancrede determined to use his influence with the patient, and her friends, to induce them to consent to the operation, and requested me to make every preparation for its performance—in case I approved of and was willing to undertake it. Coinciding with him in sentiment, and having considerable time for reflection, and opportunity for examining authorities as to the best mode of performing the operation, I made all the necessary arrangements.

On Wednesday, 25th of March, 1835, I received notice that Mrs. R—— was in labour; and at 3 o’clock, P. M., saw her, for the first time, with Drs. Nancrede and F. S. Beattie. Labour had commenced the night before, though the pains during that night, and the whole of Wednesday, were slight. The os uteri, however, had dilated sufficiently to admit two or three fingers, but the membranes remained entire. In this state of affairs it was explained to Mrs. R——, by Dr. Nancrede, and the Rev. Mr. Hughes her pastor, that it was deemed improper, in every point of view, to destroy her child, and that it was her duty to risk her own life in the hope of saving that of her offspring.

* Meigs on Deformed Pelvis, &c., in Baltimore Medical and Surgical Journal and Review, vol. 2nd, p. 30.

After consulting for some time with her husband, and other friends, she consented to have the operation of Cæsarian section performed.* A firm table was selected, and covered with a mattress and sheets, the patient placed upon it, on her back, and her pelvis and shoulders supported by pillows. In presence of Dr. Nancrede, Professor Dewees, Dr. Dove of Richmond, Professor Horner, Dr. Beattie, Dr. Wm. Coxe, Dr. Theodore Dewees, and my son, Charles Bell Gibson, I made an incision, at the centre of the linea alba, commencing about an inch below the umbilicus, through the integuments, and extending nearly to the pubes. To save the patient pain and to prevent this first, or perpendicular, cut from penetrating too deeply, I requested Dr. Horner to fold up the skin with his fingers, and while thus held I passed the knife through it with its back towards the abdomen. The superficial fascia being exposed was divided, then the tendons of the abdominal muscles, next the peritoneum, and lastly the body of the uterus, all to the extent of six inches. The uterus, however, at this stage of the operation, was not cut entirely through, but a line or two in thickness, of the interior of its walls, left—with the view of drawing off the waters before I opened the womb, penetrated the membranes and exposed the child. At my request Dr. Nancrede introduced a finger into the os uteri and endeavoured to rupture the membranes, but could not succeed. A similar attempt was made by Dr. Beattie, which also failed. Having resumed the knife, the remaining fibres of the uterus were divided, the membranes exposed, and cautiously opened by running Cooper's bistoury for strangulated hernia, upwards and downwards, to the extent of six inches, while Dr. Horner held closely together the sides of the wound, to prevent protrusion of the intestines and the escape of any portion of the waters into the bag of the peritoneum.

There was a right lateral obliquity of the uterus, and the position of the child found to correspond with the third breech presentation of Baudelocque. Dr. Beattie then introduced his hand, and drew out the feet, while Dr. Nancrede supported the hips and back, and removed the body, and lastly, the head

* There are several modes of performing Cæsarian section, but I prefer the one I have here described.

of the child, from the womb. It proved a girl of large size, and apparently healthy. For some seconds, however, it did not breathe, and, indeed, not until friction on the chest, blowing into the mouth, and the introduction of a few drops of brandy were resorted to. The cord being cut, the child was removed, and in a short time cried lustily. Whilst Dr. Horner still kept the sides of the wound together, Dr. Beattie extracted, without difficulty, the placenta and membranes, and, at the same time, pushed a finger from the interior of the uterus through the os tinæ, to make a free communication with the vagina. During these manipulations, two portions of intestine, each the size of a pigeon's egg, protruded on the right side of the uterus, and near the upper corner of the wound. They were readily kept back, however, and did not again protrude; nor did any fluid, so far as could be observed, find its way into the peritoneal bag. No hemorrhage took place from the removal of the placenta, nor was it necessary to secure a single vessel with the ligature. There was a visible contraction of the womb, after the removal of its contents, and the incision in it had sensibly shortened in the course of a few seconds.

My attention was next drawn towards closure of the wound. With great care, and the utmost nicety, the edges of the peritoneum, muscles, and integuments were held together by assistants, while I passed, successively, three stout silk ligatures, in form of interrupted suture, through the integuments—avoiding the peritoneum and muscles—an inch and a half from each other, and supported the whole by adhesive straps, lint, a compress and roller around the abdomen. To give vent to any secretion of serum, or pus, the lower angle of the wound was left open for the space of half an inch. The patient was then raised very carefully, by several assistants, and laid in bed upon her back, and great pains taken to render her position as comfortable as possible, and to prevent the slightest movement. There was less difficulty in this respect than could have been anticipated, arising partly from the little pain, comparatively, during the operation, the natural firmness and equanimity of the patient, and her faithful reliance upon Providence for a happy issue out of her affliction. Under the cheering influence of such feelings, she slept soundly for several hours, and did not change her position in the slightest degree.

By Drs. Nancrede, Beattie and myself,* she was visited, for a week or ten days, three times a day; was kept entirely on barley water, during that time, under the influence of an occasional opiate at night, took, now and then, small doses of magnesia, or used enemata, had her diet gradually increased; on the twenty-fifth day after the operation, was enabled to sit up,—the wound, with exception of a single spot, the size of a pea, being entirely cicatrized—and, finally, recovered, and now enjoys, together with her child, perfect health.

On Cæsarian Section, consult *Sabatier's Medecine Operatoire*—Simon in *Mem. de l'Acad. de Chirurg.* tom. 3d, and 5th edit. 12mo.—*Baudelocque Traité des Accouchemens*—*Hull's Defence of Cæsarian Section*, 8vo.—*C. Bell in Med. Chir. Transact.* vol. 4th—*I. H. Green, ibid.* vol. 12—*Dictionnaire des Sciences Medicales*, tom. 17—*Plancon Traité complet de l'Operation Cæsarienne.* Paris, 1801—*Ansiaux's Dissertation sur l'Operation Cæsarienne, &c.* Paris, 1803—*Dewees' Midwifery*—*Essays, Cases, &c.* by the following writers, may be consulted with advantage:—*Kaiserschnitt, Weinhart, Nettman, Rhode, Wigand, Flammant, Kulenthal, Meyer, Ploderl, Huter, Kittel, Friedemann, Graefe, Bobertag, Wanner, Papius, Davidsohn, Michaelis, Siebold*; an account of which may be found in *Dictionnaire de Medecine, ou repertoire Generale des Sciences Medicales*, tom. Septieme, p. 156. Paris, 1834—The 7th vol. of *Sprengel, Histoire de la Medecine*, and *Cooper's Surgical Dictionary*, may also be referred to. But the most elaborate work ever published on the Cæsarian section, is said to have been written lately by *Mansfeldt*, a German surgeon; for an account of which, see *Ryan's Manual of Midwifery*.

* After the operation the patient was kindly visited, repeatedly, by Drs. Dewees, William Coxe, Horner, Spackman and others.

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